Eyecare Center of Leesburg
Optometrist
Premium eyecare & affordable eyewear since 1987

Name: ______________________
Date: ________________________

Electronic Medical Records Information

We are now using government certified Electronic Medical Records software and request the following information. Please circle or write in your answers.

Marital Status:
- Single
- Married
- Widowed
- Domestic Partner

Ethnicity:
- Hispanic
- Non-Hispanic
- Declined

Smoking:
- Current every day
- Current some days
- Former smoker
- Never Smoked
- Heavy tobacco use- other than smoking (i.e. chew)
- Light tobacco use- other than smoking

Race:
- African American or Black
- American Indian
- Asian
- Native Hawaiian/Pacifier
- Caucasian/White
- Declined

Alcohol Use:
- None
- Social
- Moderate (drink daily)
- Excessive (multiple drinks daily)
- Previous

Other Social History (*please circle all that apply*):
- Sexually active
- Sexual disease
- History of abuse
- History of domestic violence

Drug Use:
- None
- Hist of substance abuse
- Social

Your Primary Doctor Information
Name: ____
Phone: ____

Known Allergies (meds or other):
____
Reaction: ____

Height: ______ **Weight**: _____
Medications: ____

Any other **Medical History** we should know:
Personal: HBP Diabetes Glaucoma Cancer other: _________________
Family: HBP Diabetes Glaucoma Cancer other: __________________

Who in Family: ____