PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

Today's Date:_____ Date of Birth:_____

Gender _____ Home # _____ Cell # _____

Primary Language ☐ English ☐ Other _____ Race _____ Ethnicity _____ ☐ Decline Info

Address _____ Apt # _____ City _____ State _____ Zip _____

Dr. Seeing Today _____ Primary Care Physician _____

Who Referred You Here? _____ Email: _____

Reason for Today's Visit: _____

Primary Insurance _____ ID# _____ Group# _____

Subscriber's Last Name _____ First Name _____ Date of Birth _____

Social Security # _____ / _____ / _____ Relationship to Insured _____

Employer's Name & Address _____

Secondary Insurance _____ ID# _____ Group# _____

Subscriber's Last Name _____ First Name _____ Date of Birth _____

Social Security # _____ / _____ / _____ Relationship to Insured _____

Eye History: (check all applicable)

☐ Glasses ☐ Contact Lenses ☐ Dry Eyes ☐ Glaucoma ☐ Cataracts ☐ Macular Degeneration

☐ Lazy or Crossed Eye ☐ Eye Injury or Surgery (describe) _____

List Eye Medications _____

Medical History: (check all applicable)

☐ Diabetes ☐ Hypertension ☐ Thyroid Disease ☐ Hepatitis ☐ Sinusitis ☐ Arthritis

☐ HIV Positive ☐ List Other Medical Problems _____

Medication including non-prescription: (please list)

_____

_____

_____

Preferred Pharmacy Name and Address _____

Drug Allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Other

Previous Surgeries: (please list) _____

Family History: ☐ Glaucoma (who _____) ☐ Macular Degeneration (who _____)

Social History: Occupation _____ Marital Status: ☐ Single ☐ Married ☐ Widowed

Review of Systems: (check all applicable)

☐ Headache	☐ Fever	☐ Chest Pain	☐ Skin Rashes	☐ Palpitations
☐ Breathing Problems	☐ Kidney/Bladder Problems	☐ Joint Pain	☐ Hay fever	☐ Bleeding Problems
☐ Breast Lumps	☐ Prostate Problems	☐ Numbness/Tingling	☐ Sinus Problems	☐ Seizures
☐ Hearing Problems	☐ Digestive Problems	☐ Loss of Appetite	☐ Abnormal Blood	☐ Emotional Problems

Do You Smoke? ☐ Never ☐ Yes ☐ Sometimes Year became smoker _____

☐ Former smoker (approx. start date _____ Quit date _____)

If you are 65 years of age or older	Have you had a fall in the last year? ☐ Yes ☐ No Have you ever received a pneumoccal vaccination? ☐ Yes ☐ Unknown