PATIENT INFORMATION

NAME: FIRST______________ MIDDLE INITIAL______ LAST______________

ADDRESS______________ CITY______________ STATE______ ZIP______

CELL PHONE______________ HOME______________ DATE OF BIRTH______________ o Male o Female

EMAIL ADDRESS______________ EMPLOYER/ OCCUPATION______________

DO YOU WEAR GLASSES?________ WHEN? FULL-TIME______ DISTANCE______ NEAR/READING______ SAFETY______

DO YOU WEAR CONTACT LENSES?______ BRAND______________ PROBLEMS OR CONCERNS W/ CONTACTS?__________ ARE YOU INTERESTED IN CONTACTS?__________

DATE AND PLACE OF LAST EYE EXAM______________

REASON FOR TODAY'S VISIT______________

REVIEW OF SYSTEMS DO YOU HAVE OR HAVE YOU HAD... Circle "Y" (yes) or "N" (no).

EYES		
Eye Drop Use	Y	N
Eye Surgery	Y	N
Eye Injury	Y	N
Eye Infection/Disease	Y	N
Dry Eyes	Y	N
Itchy Eyes	Y	N
Lazy Eye (Amblyopia)	Y	N
Glaucoma	Y	N
Macular Degeneration	Y	N
Cataracts	Y	N
ENDOCRINE		
Diabetes	Y	N
Thyroid	Y	N
PREGNANT NOW?	Y	N

EAR, NOSE, THROAT, HEAD		
Allergies	Y	N
Headache	Y	N
NEUROLOGICAL		
Migraine	Y	N
Seizures	Y	N
SKIN		
Cancer on Face	Y	N
Acne Rosacea	Y	N
VASCULAR		
High Blood Pressure	Y	N
High Cholesterol	Y	N
Heart Problems	Y	N
Stroke History	Y	N
PSYCHIATRIC ISSUES	Y	N

RESPIRATORY		
Asthma	Y	N
COPD	Y	N
GASTROINTESTINAL		
Acid Reflux	Y	N
Colon Disease	Y	N
GENITOURINARY		
Kidneys/Bladder	Y	N
Dialysis	Y	N
BONES, JOINTS, MUSCLES		
Arthritis	Y	N
Rheumatoid Factor	Y	N
CANCER	Y	N
OTHER__________		

MAJOR SURGERY______________

FAMILY HISTORY Do any of your parents, grandparents or siblings have... Circle "Y" (yes) or "N" (no).
GLAUCOMA? Y N CATARACTS? Y N DIABETES? Y N RETINAL DETACHMENT? Y N MACULAR DEGENERATION? Y N

MEDICATIONS YOU ARE TAKING (Do you have a list to copy?)______________

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ALLERGIES TO MEDICATIONS OR ENVIRONMENT______________

DO YOU SMOKE? Y N HOW MUCH?__________ ALCOHOL? Y N HOW MUCH?__________ STREET DRUGS? Y N

HOW DID YOU HEAR ABOUT OUR OFFICE? Return patient Insurance Advertisement Walk-in Internet Family/Friend______________

PRIMARY CARE PROVIDER______________ PHONE______________

PERSON TO CONTACT IN CASE OF EMERGENCY______________ PHONE______________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I directly assign to the doctor all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The doctor may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature______________ Print______________ Date______________
(Signature of Patient, Parent, Guardian or Personal Representative)