WELCOME TO OUR OFFICE

Seth Jenkins, OD
2101 Plaza St
Rawlins, WY 82301
307-324-2601

Please print and complete form entirely, front and back

Name _____
Address _____
_____
City _____ State_____ Zip _____
Phone: Home _____ Cell _____
Patient's Social Security # _____
Employer _____ Occupation _____

Medical Insurance Company
Primary _____
Secondary _____
Vision Insurance _____

EYES

Do you wear glasses? Y N How old are they?_____
Do you wear contacts? Y N What type?_____
Are you planning to get new glasses ? Y N unsure
Eye surgery (ie. LASIK, PRK, cataract): _____

Check the following if you have any of these conditions:

Cataract _____
Macular Degeneration _____
Glaucoma _____
Diabetes _____
Diabetic Retinopathy _____
Dry Eye _____
Eye Infection/Inflamtion/Allergy _____
Floaters/Flashes _____
Iritis/ Uveitis _____
Retinal Defect _____
Color Blindness _____
Redness _____
Burning _____
Itching _____
Tearing _____
Discharge _____
Blurred Vision _____
Eye Strain _____
Eye Pain _____
Sensitivity to light _____
Headache _____
Poor Night Vision _____
Bothersome Night Glare _____
Double Vision

Today's Date _____ Date of Last Eye Exam _____
Date of Birth _____ Spouse Name _____
Email address _____
What is the reason for your visit today? _____
_____

Person Financially Responsible for Account (must be 18 or older)
Name _____ ( )same
Address _____ ( )same
City _____ State_____ Zip_____ ( )same
Social Security # _____ ( )same
Drivers Lic. No. _____
Responsible's Employer _____ ( )same
Years there _____ Work Phone _____
Phone: Cell Home

Personal Medical History

Date of last MEDICAL visit: _____
Name of Physician: _____
Name of Pharmacy: _____

Please List **ALL Current Medications** Rx & OTC (or provide a list)
Include any eye drops, sleeping pills, oral contraceptives or vitamins

_____
_____
_____
_____

Allergies to Medications _____
_____

Social Environmental History

Do you participate in the following?
Smoke tobacco _____
Chew Tobacco _____
Drink Alcohol _____
Drive a Vehicle _____

Hobbies
_____
_____

INSURANCE REQUIRES THAT CO-PAYMENTS AND OVERAGES ARE DUE AT TIME OF SERVICE
YOUR BILL IS YOUR RESPONSIBILITY

MEDICAL CONDITIONS

Have you ever had problems with any of the following areas of your body?

(Check those that apply and leave those that do not apply blank)

CONSTITUTIONAL
- ☐ Developmental Disabilities
- ☐ **Cancer** of_____
- ☐ Fatigue Syndrome

EARS,NOSE,MOUTH,THROAT
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Chronic Dry Throat/Mouth
- ☐ Laryngitis

NEUROLOGIC
- ☐ MS
- ☐ Epilepsy
- ☐ Tumor
- ☐ Migraines
- ☐ Autism

PSYCHIATRIC
- ☐ Depression, Clinical
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Bipolar

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Stroke /CVA
- ☐ Heart Disease/Pain
- ☐ Vascular Disease

RESPIRATORY
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Sleep Apnea

GASTROINTESTINAL
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Stomach Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease

GENITOURINARY/REPRODUCTIVE
- ☐ Kidney Stones
- ☐ Bladder Infections
- ☐ Pregnant

MUSCLE/JOINT/BONES
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Gout
- ☐ Osteoarthritis

INTEGUMENTARY
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis

ENDOCRINE
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Thyroid
- ☐ Hormonal Dysfunction

HEMATOLOGICAL/LYMPH
- ☐ Anemia
- ☐ High Cholestrol

ALLERGIES/IMMUNE
- ☐ Allergies /Hayfever
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ HIV+
- ☐ Rheumatoid Arthritis

If you have a condition not listed, please explain:

_____

FAMILY HISTORY

(Living or deceased)

What is the Relationship to you?
(Parent, Sibling, Child)

Medical
- ☐ Cancer _____
- ☐ Diabetes Type 1 _____
- ☐ Diabetes Type 2 _____
- ☐ Hypertension _____
- ☐ Heart Disease _____

Ocular
- ☐ Macular Degeneration _____
- ☐ Cataract _____
- ☐ Glaucoma _____