Welcome To Our Office!

Patient Information	
Name (FULL LEGAL)	DOB ______/_______/_______
Street Address	
City/State/Zip	
Occupation	Employer
Home Phone	Cell
Email Address (used only for appointment reminders)	

please let the front desk know if your doctor needs a copy of todays exam.

Primary Care Physician (please list as much information as you know)

Name____ City of Practice________________________

Phone____ Fax__________________________________

By Signing below I acknowledge and give my consent

That I am the patient listed above or their guardian/representative and the information is up to date and correct to the best of my knowledge.

I authorize the release of any medical or other information to process my insurance claims. I also authorize payment of medical benefits to my doctor. It is my understanding that I am responsible to obtain any and all referrals that my insurance company requires for service performed by the doctor. I also understand that I that am responsible for any charges not covered by my insurance.

I have been presented with, read and understand the Notice of Privacy Policy For Boardman Family EyeCare. A copy to keep for my records is available at my request.

Patient Signature____ Date______________

(If under 18 please have a guardian sign)

Medical History

Please check if you have any of the following:

Constitutional
- ☐ developmental disability
- ☐ fever
- ☐ fatigue
- ☐ weight loss

Gastrointestinal
- ☐ Crohn's
- ☐ colitis
- ☐ ulcer
- ☐ digestive disorder

Neurological
- ☐ multiple sclerosis
- ☐ epilespy
- ☐ migraines
- ☐ seizures

Psychiatric
- ☐ depression
- ☐ panic disorder
- ☐ anxiety disorder
- ☐ schizophrenia

Cardiovascular
- ☐ high cholesterol
- ☐ hypertension
- ☐ stroke
- ☐ vascular disease

Musculoskelital
- ☐ fibromyalgia
- ☐ muscular dystrophy
- ☐ rheumatoid arthritis
- ☐ lupus

Endocrine
- ☐ non-insulin diabetes
- ☐ insulin diabetes
- ☐ thyroid dysfunction
- ☐ pituitary dysfunction

Respiratory
- ☐ cigarette smoker
- ☐ asthma
- ☐ lung cancer
- ☐ emphysema

Integumentary
- ☐ eczema
- ☐ rosacea
- ☐ psoriasis
- ☐ steven's johnson

Hematological
- ☐ anemia
- ☐ leukemia
- ☐ sickle cell
- ☐ clotting disorder

Genitourinary
- ☐ urinary tract infections
- ☐ kidney ailments
- ☐ STD
- ☐ kidney dialysis

Ears/Nose/Throat
- ☐ oral Cancer
- ☐ inner ear infection
- ☐ sinus infection(s)
- ☐ sleep apnea

Are you currently pregnant or nursing? Yes No

Current Medications____

____

Allergies____

Eye Health History

Past History

- ☐ Cataract
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Diabetic Retinopathy
- ☐ Lazy Eye
- ☐ Eye injury
- ☐ Retinal Detachment
- ☐ Corneal Disease

Have you ever had any eye surgeries? Yes No Please explain________________________

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