Patient Information

Name: _____ **Birthdate:** _____/_____/_____ **Sex:** M F

Street Address: _____ **City/State/Zip:** _____

Home Phone: ( )_____ **Cell Phone:** ( )_____ **Work Phone:** ( )_____

Social Security#: _____/_____/_____ **Email:** _____

Do you have eye insurance? Yes No Name of insurance company: _____

Do you have medical insurance? Yes No Name of insurance company: _____

How did you learn of our office? □ Relative □ Friend □ Insurance □ Website □ Phonebook □ Previous Patient

Do you wear glasses? Yes No Contact lenses? Yes No Relationship Status: _____

Have you had eye surgery? Yes No What kind: _____ Date: _____

Have you had an eye injury? Yes No What kind: _____ Date: _____

Primary Care Physician: _____ Last visit with your PCP: _____

YOUR MEDICAL HISTORY Do you have or have you had in the past any of the following conditions:

High Blood Pressure	No Yes	Diabetes	No Yes	Heart Disease	No Yes
Cancer	No Yes	Arthritis	No Yes	Thyroid Disease	No Yes

List all medications that you are currently take. (Include oral contraceptives, aspirin, over the counter medications and home remedies): **If you have a list we can make a copy instead.** _____

_____

Are you pregnant, nursing and/or do you think you may be pregnant? No Yes

List all major surgeries and/or hospitalizations you have had: _____

_____

Are you allergic to any medications? No Yes If yes please list: _____

_____

YOUR FAMILY HISTORY Do any of your blood relatives have the following conditions:

Crossed eyes	No Yes	Diabetes	No Yes	Heart disease	No Yes
Lazy Eye	No Yes	Thyroid disease	No Yes	Cancer	No Yes
Macular Degeneration	No Yes	High blood pressure	No Yes	Retinal detachment	No Yes
Glaucoma	No Yes				

YOUR EYE HISTORY Do you have or have you had in the past any of the following conditions:

Crossed eyes	No Yes	Glaucoma	No Yes	Retinal detachment	No Yes
Lazy Eye	No Yes	Macular Degeneration	No Yes	Cataract	No Yes

YOUR SOCIAL HISTORY

Do you use tobacco products? No Yes If yes, how many packs/cigars per day: _____

Do you drink alcohol? No Yes If yes, how many drinks per day: _____

What is the reason for today's exam?_____

--------OVER--------

REVIEW OF SYSTEMS Do you currently have any of the problems listed below?

Eyes:

Loss of side vision	No	Yes
Blind spot in vision	No	Yes
Distorted vision/halos	No	Yes
Mucous discharge	No	Yes
Burning eyes	No	Yes
Dry eyes	No	Yes
Red eyes	No	Yes
Watering eyes	No	Yes
Itching	No	Yes
Light sensitivity	No	Yes
Flashes	No	Yes
Floaters	No	Yes
Double vision	No	Yes

Constitutional:

Recent fevers	No	Yes
Weight gain/loss	No	Yes

Neurological:

Headaches	No	Yes
Numbness	No	Yes

Ears/Nose/Throat:

Hearing loss	No	Yes
Sinus infection	No	Yes
Sore throat	No	Yes

Endocrine:

Frequent urination	No	Yes
Frequent thirst	No	Yes

Respiratory:

Sleep apnea	No	Yes
Breathing difficulty	No	Yes
Chronic cough	No	Yes

Vascular/Cardiovascular:

Chest pain	No	Yes
Irregular heart beat	No	Yes
Swelling of legs	No	Yes

Gastrointestinal:

Gastric reflex/Heartburn	No	Yes
Abdominal pain	No	Yes

Genitourinary:

Crohn's disease	No	Yes
Painful urination	No	Yes
Blood in urine	No	Yes

Bones/Joints/Muscles:

Swollen joints	No	Yes
Joint pain	No	Yes
Muscle aches	No	Yes

Lymphatic/Hematologic:

Anemia	No	Yes
Bleeding problems	No	Yes
Swollen glands	No	Yes

Psychiatric:

Depression	No	Yes
Anxiety	No	Yes

Allergic/Immunologic:

Autoimmune disorders	No	Yes
Airborne allergies	No	Yes
Frequent infections	No	Yes

If you answered yes to any of the questions, please explain: _____

_____

Patient or Parental Signature: _____ Date: _____/_____/_____

Return Visits Patient Reviewed for Changes: Date: _____/_____/_____ Initial: _____ Date: _____/_____/_____ Initial: _____