

Today's Date: ____ / ____ / ____
 Name: _____
 Address: _____
 City: _____
 Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Work Phone: _____
 Email Address: _____
 Medical Insurance: _____
 Social Security #: _____
 Occupation (or Grade): _____
 Birth Date: ____ / ____ / ____
 Age: _____

Very important! New patients only:

Who may we thank for referring you to our office? Name of friend or relative:

Or, how else did you choose our office?

Another Doctor. Which one?

Insurance List

Saw Sign/Building

Internet

Other _____

Medical History

Do you have any allergies to medications? No Yes If yes, what medicines? _____

Please list all medication(s) that you are currently taking: (If none, check here.)

List any of the following that you have had: crossed eyes, lazy eyes, glaucoma, retinal disease/macular degeneration, cataracts, eye injury, or eye surgery:

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

<u>DISEASE/CONDITION</u>	<u>NO</u>	<u>YES</u>	<u>?</u>		<u>NO</u>	<u>YES</u>	<u>?</u>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Review of Systems:

Do you currently, or have you ever had any problems in the following areas:

<u>SYSTEM</u>	<u>NO</u>	<u>YES</u>	<u>?</u>	<u>SYSTEM</u>	<u>NO</u>	<u>YES</u>	<u>?</u>
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Dry Throat/ Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY			
EYES				Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARDIOVASCULAR			
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Chronic Infections of Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				GENITOURINARY			
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LYMPHATIC / HEMATOLOGIC				Genital / Kidney / Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES			
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ATTESTATION

I have read and understand, to the best of my knowledge, the above information. I certify that all statements are truthful and accurate. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that I am financially responsible for any service considered non-covered, any deductibles and/or co-payments as well as any service denied due to non-participating provider.

Patient or Parent or Guardian Signature _____
Date

CERTIFICATION: ATTENDING PHYSICIAN HAS REVIEWED THE ABOVE MEDICAL/EYE HISTORY

Doctor's Signature _____
Date