PATIENT INFORMATION

PATIENT NAME: _____ **SEX: M F**
LAST FIRST M.I. NICKNAME

ADDRESS: _____ **Apt No:** _____

_____ **BIRTHDATE:** ____/____/_____
CITY STATE ZIP

E-MAIL: _____ **HOME PHONE:** _____

WORK PHONE: _____ **CELL PHONE:** _____

SOCIAL SECURITY #: _____ **MARITAL STATUS: (Circle One) M S D W**

PRIMARY LANGUAGE: _____ **HISPANIC/LATINO: Yes ____ No____**

RACE: (Circle One) WHITE AFRICAN-AMERICAN NATIVE-AMERICAN ASIAN
HIAWAIIAN/PACIFIC ISLANDER OTHER _____

PRIMARY CARE DOCTOR: _____

DIABETICS: PLEASE LIST LAST A1c (Normal 4.0-6.0) ___.___. DATE TAKEN: ____/____/_____.

Who referred you to our practice? _____

Who else can we speak with regarding your medical records (Give full name(s)): _____

_____

PLEASE COMPLETE IF DIFFERENT THAN PATIENT:

INSURANCE POLICYHOLDER: _____
LAST FIRST M.I. RELATIONSHIP

___/___/_____ _____-_____-_____
BIRTHDATE SOCIAL SECURITY #

PERSON RESPONSIBLE FOR ACCOUNT: _____
LAST FIRST M.I.

ADDRESS: _____

RELATION TO PATIENT: _____ **PHONE NUMBER:** _____

I understand that my vision insurance cannot be billed if I am diagnosed with a medical condition and instead will be billed under my medical insurance. I will be responsible for co-payments, co-insurance and deductible amounts. Our refraction fee is $30.00.

Signature: _____

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Birthdate: ____/____/____ Date: ___/____/____

REASON FOR VISIT:
___ Cataract ___ Diabetes ___Glaucoma ___Macular Degeneration ___Other Specify: _____

_____ Prescription for Glasses/Contacts (**some insurances and Medicare, <u>will not pay</u> <u>for this service</u>**)

_____ Infection/Injury/Irritation of the Eye/Flashes or Floaters, please describe:
Location: _____
Duration: _____hours _____days _____weeks _____months
Severity: _____mild _____moderate _____severe
Quality: _____
Symptoms: _____

Primary Care Physician: _____ Last Visit: ___/___/_____
Referring Physician: _____ Last Visit: ___/___/_____

Diabetics: Last A1c: _____ (or Last Blood Sugar _____) Date of A1c: ___/___/_____
Date Diagnosed with Diabetes: ___/___/_____

SURGERIES (Check all that apply):

Procedure (Eye)	Surgeon	Date	Procedure	Surgeon	Date
____Cataract (R/L)	_____		____Cosmetic	_____	
____LASIK/ PRK (R/L)	_____		____Other	_____	
____Glaucoma (R/L)	_____				
____Retina (R/L)	_____				
____Eye Muscle (R/L)	_____				

REVIEW OF SYSTEMS: Do you have any problem in the following areas? **Check all that apply**:

Constitution
____Bleeding Problems
____Headaches
____Seizures
____Weight Loss

Cardiovascular
____Bypass Surgery
____Heart Stints
____Heart Attack
____Pacemaker
____Hypertension
____ Heart Murmur
____ High Cholesterol
____ Irregular Heart Beat
____ Heart Valve Problem
____ Stroke

Respiratory
____ Asthma
____ COPD
____ Lung Cancer
____ Pneumonia
____ Sarcoid
____ TB

ENT
____Hearing Loss

GI
____Reflux (GERD)
_____ Hernia
_____ Gallbladder
_____ Hepatitis

GU
____Bladder
____Kidney
____Prostate
____Urinary

Musculoskeletal
____Arthritis
____Cerebal Palsy
____MS
____Rheumatoid Arthritis

Integumentary
____Basal cell
____Dermatitis
____Rosacea
____

Neurologic
____Bells Palsy
____Dizziness
____Migraine
____TIA

Psychiatric
____Depression
____Dementia
____Anxiety

Endocrine
____Diabetes
____Thyroid
____

Blood/Lymphatic
____Anemia
____Hemophilia
____Leukemia
____HIV

Smoking History:

Check One:
____ Daily Smoker
____ Former Smoker
____ Never Smoked

Tobacco Users Check One
____Cigarettes
____Cigar
____Vape

Alcohol History

Check One:
____Non Drinker
____ Social Drinker
____ Daily Drinker

Do you use Recreational Drugs (Circle One): ____ Yes ____ No **If yes**, type used: _____

PLEASE CHECK ALL THAT APPLY:

	Past or Present Eye Problems	**Family History (Mother, Father, Child)**
Glaucoma	____	_____
Cataracts	____	_____
Macular Degeneration	____	_____
Eye Injury	____	_____
Retinal Disease	____	_____
Loss of Eye	____	_____
Blindness	____	_____
Eye Muscle Problems	____	_____
Amblyopia/Lazy Eye	____	_____
Dry Eye	____	_____
Refractive Surgery	____	_____
Diabetes	____	_____
Cancer	____	_____
Heart Disease	____	_____
Thyroid Problems	____	_____

List current medications, OTC and supplements you take:

Name of Current Medication	**Taken for what condition**	**Dosage**	**Frequency**

Allergies (Check all that apply):

____ Penicillin
____ Aspirin
____ Codeine
____ Erythromycin

____Fluorescein
____Sulfa
____Tetracycline
____Dairy Products

____Cipro
____Bactrim
____Thimerosal
____LATEX

___ Other: Please list
_____
_____
_____

Pharmacy: _____
Name Address

Females: Please check if pregnant: _____YES _____ NO