

PERSONAL INFORMATION

Patient Name		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	Date of Birth	Age
Street Address	City	State/Zip	Home Number		
Occupation	Employer or Name of School		<input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student		
Work Address	City	State/Zip	Work Number		
Spouse or Guardian			Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (If different from patient's)	City	State/Zip	Home Phone		
Occupation	Employer		Work Phone		
Work Address	City	State/Zip	Social Security Number		

INSURANCE INFORMATION

Primary Insurance Company		Member ID Number	
Insurance Company Address	City	State/Zip	Group Number
Insured's Name	Relation to Patient	Date of Birth	Social Security Number
Insured's Address (If different from patient's)	City	State/Zip	Home Number
Secondary Insurance Company		Member ID Number	
Insurance Company Address	City	State/Zip	Group Number
Insured's Name	Relation to Patient	Date of Birth	Social Security Number
Insured's Address (If different from patient's)	City	State/Zip	Home Number

EMERGENCY CONTACT

Name	Relationship to Patient	Phone Number
Address	City	State/Zip

Which of the following influenced you to choose our office:

Other Doctor Yellow Pages Friend/Relative Newspaper Other

I understand that I am responsible for all financial obligations of health services and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all billing charges, interest charges, collection costs and reasonable legal fees.

Signed - Patient or Guardian

Date

PATIENT NAME _____ DATE OF BIRTH _____

Referring Doctor _____ Family Doctor _____

Address _____ Address _____

Phone # _____ Phone# _____

Fax# _____ Fax# _____

Medications with dosages: _____ Do you have allergies to any medications? NO YES If yes, list: _____

_____ Do you take aspirin, ibuprofen or a blood thinner? NO YES

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.)

List any surgeries you have had: (cataract, tonsillectomy, etc.) _____

REASON FOR VISIT: Check conditions you currently have.

<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Seeing flashes or halos	<input type="checkbox"/> Sandy or gritty feeling	<input type="checkbox"/> Eye pain or soreness
<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Glare or light sensitivity	<input type="checkbox"/> Itching	<input type="checkbox"/> Infection of eye or lid
<input type="checkbox"/> Fluctuating vision	<input type="checkbox"/> Dryness	<input type="checkbox"/> Burning	<input type="checkbox"/> Tired eyes
<input type="checkbox"/> Double vision	<input type="checkbox"/> Mucous discharge	<input type="checkbox"/> Excess tearing or watering	<input type="checkbox"/> Crossed eyes
<input type="checkbox"/> Loss of side vision	<input type="checkbox"/> Redness	<input type="checkbox"/> Foreign body sensation	<input type="checkbox"/> Drooping eyelids
<input type="checkbox"/> Other _____			

REVIEW OF SYSTEMS: Do you currently have any problems in the following areas? If "YES", provide explanation.		OFFICE USE
GENERAL/CONSTITUTIONAL (fever, weight loss, other)	NO YES _____	
EAR, NOSE, THROAT (sinus, ear infection, cough, dry mouth)	NO YES _____	
CARDIOVASCULAR (heart disease, high blood pressure, etc.)	NO YES _____	
RESPIRATORY (asthma, emphysema, short of breath, etc.)	NO YES _____	
GASTROINTESTINAL(stomach ulcers, intestinal disease, etc.)	NO YES _____	
GENITAL, KIDNEY, BLADDER (urinary tract infection, etc.)	NO YES _____	
MUSCLES, BONES, JOINTS (arthritis, cramps, etc.)	NO YES _____	
SKIN (acne, lesions or warts, skin cancer, etc.)	NO YES _____	
NEUROLOGICAL (numbness, headaches, MS, seizures, etc.)	NO YES _____	
PSYCHIATRIC (anxiety, depression, insomnia)	NO YES _____	
ENDOCRINE (diabetes, hypothyroid, etc.)	NO YES _____	
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, etc.)	NO YES _____	
ALLERGIC / IMMUNOLOGIC (hay fever, lupus, hives, etc.)	NO YES _____	

FAMILY HISTORY: (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? NO YES UNKNOWN

BLINDNESS, CATARACT, GLAUCOMA, DIABETES, HYPERTENSION, HEART DISEASE, STROKE, CANCER, THYROID DISEASE, ARTHRITIS

Other heritable disease: _____

SOCIAL HISTORY:

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? NO YES

Have you ever had a blood transfusion? NO YES

Do you drink alcohol? NO YES If YES, how much? _____

Do you smoke? NO YES If YES, how much? _____ How many years? _____