PATIENT INFORMATION

DATE:_____

NAME:_____
LAST FIRST MIDDLE

BIRTHDATE:____/____/____ **AGE:**____

SOCIAL SECURITY NUMBER:____-____-____ **SEX:**☐ **MALE** ☐ **FEMALE**

ADDRESS:_____

_____
CITY STATE ZIP CODE

HOME PHONE:(___)____-____ **WORK:**(___)____-____ **CELL:**(___)____-____

E-MAIL:_____ **OCCUPATION:**_____

REASON FOR VISIT:_____

REFERRED BY:_____

ALTERNATE CONTACT:_____(___)____-____
(NAME OF SOMEONE NOT AT SAME ADDRESS) TELEPHONE

PHARMACY:_____(___)____-____
TELEPHONE

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PATIENT'S PERSONAL HISTORY

1. **When was your last exam?**_____

2. **Do you wear glasses?** ☐ **YES** ☐ **NO (if no skip to question #5) Do you wear contact lenses?** ☐ **YES** ☐ **NO**

3. **When do you wear glasses/contact lenses?** ☐ **for distance** ☐ **for reading** ☐ **for both**

4. **When was the prescription of your glasses changed?**____/____
month year

5. **Have you had any of the following problems?**
☐ **Cataracts** ☐ **Glaucoma** ☐ **Eyes turn in or out**
☐ **Dry eyes** ☐ **Retinal problems (macular degeneration, diabetic retinopathy, detachment)**

6. **Your Family Physician/ Internist:**_____(___)____-____
TELEPHONE

7. **Do you have any DRUG ALLERGIES?** ☐ **YES** ☐ **NO If yes, list:**_____

_____

CONTINUE ON OTHER SIDE—►

8. LIST ALL MAJOR MEDICAL PROBLEMS for which you have been treated (i.e. diabetes, asthma, high blood pressure, heart attack, irregular heart rate, cancer, etc.).

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

9. List all previous SURGERIES and DATES.

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

10. List all MEDICATIONS currently taken including name and dosage.

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

11. Review of Systems

Do you currently have any of the following problems?	Yes	No	If YES, please explain:
Unexpected weight gain/loss, fatigue, fever.....	☐	☐	_____
Ear/nose/throat problems (hearing loss, sinusitis, sore throat)...	☐	☐	_____
Heart problems (chest pains, irregular heart rate).....	☐	☐	_____
Respiratory problems (shortness of breath, wheezing, coughing).	☐	☐	_____
Gastrointestinal problems (heartburn, vomiting, diarrhea).....	☐	☐	_____
Urinary problems (pain or discomfort, blood in urine).....	☐	☐	_____
Skin problems (rashes, dryness).....	☐	☐	_____
Musculoskeletal problems (muscle ache, joint pain or swelling).	☐	☐	_____
Neurologic problems (numbness, weakness, headaches).....	☐	☐	_____

12. FAMILY HISTORY ☐Glaucoma ☐Macular degeneration ☐Diabetes ☐Cancer
Other:_____

13. SOCIAL HISTORY
Do you smoke?☐YES☐NO If yes, how many packs a day?_____
Do you drink alcohol?☐YES☐NO If yes, how much? _____

I HAVE READ AND COMPLETED THE ABOVE INFORMATION. Signature_____

DO NOT WRITE IN SHADED AREA BELOW

Date	Surgery	Eye	Place	Fundus Photos	Visual fields