Last Name: ______________________________

First Name: ______________________ Nickname: ______________________

Street Address: ______________________________

City: ______________________ State: __________ Zip Code: ______________

Home Phone: ______________________ Daytime Phone (if different): ______________

Cell Phone: ______________________ May we text you: Y N

E-Mail Address: ______________________________

Referred By: ______________________________

Sex: M F Date of Birth: ______________________

Social Security Number: ______________________________

Marital Status: ______________________________

Employment Status: ______________________ Full Time Part Time

Employed By: ______________________ Occupation: ______________________

Preferred Language: ______________________________

Race:

- Native American/Native Alaskan
- Asian
- Black/African American
- Hispanic
- Native Hawaiian/Other Pacific Island
- White

Ethnicity:

- Hispanic/Latino
- Native Hawaiian/Other Pacific Island
- Not Hispanic/Latino

Insurance Type ______________________________

Name of Insured ______________________________

Insured's Date of Birth ______________________

Insured's Social Security ______________________

Communication Preferred: Email Telephone Postal

PATIENT HEALTH HISTORY

Patient Name: ______________________________ DOB: ______________

Primary Care Physician: ______________________ Date Last Seen: ______________

Medical / Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy): ______________

____

____

List all major surgeries (Eye Surgery included): ______________

____

List any allergic reactions to medications or eye drops: ______________

____

Please indicate if any of the conditions apply to you or a family member (blood relatives only)

Disease / Condition	Yourself Yes	Yourself No
Cataract	___	___
Eye Turn	___	___
Glaucoma	___	___
Macular Degeneration	___	___
Retinal Detachment	___	___

	Yes	No
Women - Are you Pregnant?	___	___
Are you breast feeding	___	___

Disease / Condition	Family Member		Relationship (Blood Relatives Only)
Blindness	___	___	______________
Eye Turn	___	___	______________
Glaucoma	___	___	______________
Macular Degeneration	___	___	______________
Retinal Detachment	___	___	______________

Other: ____

Review of Systems: Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic
- ❑ None
- ❑ Lupus (SLE)
- ❑ Rheumatoid Arthritis
- ❑ Environmental Allergies
- ❑ Seasonal Allergies
- ❑ Other (I.e.,Latex)

Ear, Nose and Throat
- ❑ None
- ❑ Sinusitis
- ❑ Upper Respiratory Tract Infection
- ❑ Other

Gastrointestinal
- ❑ None
- ❑ Crohn's Disease
- ❑ Colitis
- ❑ Acid Reflux/Ulcer
- ❑ Other

Skin/Integumentary
- ❑ None
- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Other

Psychiatric
- ❑ None
- ❑ Depression
- ❑ Bi-Polar
- ❑ Schizophrenia
- ❑ Other

Cardiovascular
- ❑ None
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Stroke
- ❑ Vascular Disease
- ❑ High Blood Cholesterol

Endocrine/Glands
- ❑ None
- ❑ Diabetes
- ❑ Hormone Dysfunction
- ❑ Thyroid Dysfunction
- ❑ Other

Respiratory
- ❑ None
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Other

Muscle/Skeletal
- ❑ None
- ❑ Arthritis
- ❑ Fibromyalgia
- ❑ Ankylosing Spondylitis
- ❑ Other

Genital/Urinary
- ❑ None
- ❑ Urinary Tract Infection
- ❑ HIV Positive
- ❑ Herpes/Chlamydia
- ❑ Other

Hematologic/Lymphatic
- ❑ None
- ❑ Anemia
- ❑ Leukemia
- ❑ Bleeding Disorder
- ❑ Other

Neurological
- ❑ None
- ❑ Multiple Sclerosis
- ❑ Epilepsy
- ❑ Tremors
- ❑ Other

General Health
- ❑ None
- ❑ Weight loss/gain
- ❑ Fever
- ❑ Fatigue
- ❑ Trauma

Social
- ❑ Tobacco Use: Current Smoker / Former Smoker
- ❑ Non—Prescription Drugs
- ❑ Alcohol Consumption
- ❑ Weight __________ Height __________

Please sign below to acknowledge that this form is current::

Signature: ______________________ **Date:** ______________ **Reviewed by Doctor's Initials** ________

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient (Print): ______________________ Date: ______________

Signature of Patient / Pt Representative (if patient is a minor or an adult unable to sign this form): ______________