PATIENT HISTORY **Today's Date:** ___________________

*****PLEASE PRESENT ALL VISION, MEDICAL, AND SUPPLMENTAL INSURANCE CARDS TO THE RECEPTIONIST*****

Patient's Full Legal Name____

Address_______________________________City_______________State________ZIP___________

Date of Birth _______________________ Sex (check one) ___Male ___Female ___Prefer Not To Answer

Race _______________ Ethnicity _______________ Preferred Language: _______________

Marital Status: (please check one) ____Single ____Married ____Divorced ____Widowed ____Separated

Home Phone _______________Cell Phone _______________Work Phone _______________

Social Security # ___________ Email address: _______________________________

Employer _______________________________Occupation _______________________

Emergency Contact _______________Phone #_______________Relationship___________

*****It is now required we obtain your email address so we can upload your visit to the patient portal.*****

List any previous surgeries with dates: _______________________________________

____

List your primary care physician _______________________Phone # _______________

Are you pregnant? ____Yes ____No Are you breastfeeding? ____ Yes ____No

Do you use alcohol? ____Yes ____No Frequency / Amount _______________________

Do you smoke? ____Yes ____No If yes, how many cigarettes do you smoke per day?____________

Have you been exposed to or infected with HIV? ____Yes ____No

REVIEW OF SYSTEMS

Do you currently have, or have you ever had any of the following problems or conditions? Please check any and all that apply.

Cardiovascular
- ___Heart Disease
- ___High Blood Pressure
- ___High Cholesterol
- ___Stroke
- ___Vascular Disease

Ears/Nose/Mouth/Throat
- ___Allergies
- ___Seasonal Allergies

Respiratory
- ___Asthma
- ___Emphysema
- ___Sleep Apnea

Gastrointestinal
- ___Crohn's Disease
- ___Hepatitis A
- ___Hepatitis B
- ___Hepatitis C
- ___Ulcer / Reflux

Musculoskeletal
- ___Joint / Muscle Pain
- ___Osteoarthritis
- ___Rheumatoid Arthritis

Integumentary
- ___Skin Cancer
- ___Skin Disease

Neurological
- ___Headaches
- ___Migraines
- ___Multiple Sclerosis
- ___Gout
- ___Seizures

Psychiatric
- ___Anxiety / Depression

Endocrine
- ___Diabetes Type 1
- ___Diabetes Type 2
- ___Thyroid / Other Glands

Lymphatic – Hematologic
- ___Lupus
- ___Organ Transplant

MEDICATIONS

List all CURRENT prescriptions, over-the-counter medications, vitamins, supplements, and eye drops and the dosages for each. If you do not currently take any medications, write "None".

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

MEDICATION ALLERGIES

List any allergies you have, along with the reaction. If you have none, write "None".

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

OCULAR HISTORY

Date of last eye exam ____________________ Previous Eye Doctor ____________________

Do you have, or have you ever had any of the following problems or conditions? Please check any and all that apply.

____Age-related Macular Degeneration ____Amblyopia (lazy eye) ____Blindness (one eye)

____Blindness (both eyes) ____Cataracts ____Glaucoma

____Laser Eye Surgery ____Injury to the eye region ____Keratoconus

____Retinopathy ____Strabismus (crossed eyes) ____Tear film insufficiency (dry eyes)

Other ____

Please list any laser eye surgeries with the date ______________________________________

FAMILY HEALTH HISTORY

Please check any of the entries below. List which family member is affected, including mother, father, brother, sister, maternal / paternal grandmother, maternal / paternal grandfather.

____Amblyopia (lazy eye) ____________________ ____Blindness / vision impairment ____________________

____Cataract ____________________ ____Macular degeneration ____________________

____Glaucoma ____________________ ____Retinal disorder ____________________

____Strabismus ____________________ ____Arthritis ____________________

____Cancer ____________________ ____Diabetes mellitus ____________________

____Hypertension ____________________ ____Cardiovascular Disease ____________________

____Stroke ____________________

Patient Signature ____

Signature of Legal Guardian / Representative ____