Welcome to Our Office

Today's Date _____

Name _____
Date of Birth _____ Sex M F
Address_____
City_____
State _____ Zip Code_____
Home Phone_____
Work Phone _____
Cell Phone _____
Email _____
Patient's SSN _____
Employer _____
Occupation_____
Spouse (or Parent) _____

What is the Purpose of this Visit?_____
_____
_____

Insurance Information

Vision Insurance_____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date_____
Member ID#_____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____
Member ID# _____
Group # _____

Patient Medical History

Primary Care Physician _____

Current Medications (Rx or Over the Counter)
List names of medications, including eye drops, vitamins and birth control:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies to Medications? Y N
If so, what medications?_____
_____
_____
Have you had any eye surgeries? Y N
If so, what surgeries? _____
_____

Family Medical/Eye History

(check all that apply)

		Relationship
Glaucoma	☐	_____
Cataracts	☐	_____
Macular Degeneration	☐	_____
Strabismus	☐	_____
Retinal Problems	☐	_____
Surgery on Eyes	☐	_____

Are you a smoker? Y N
Do you drink alcohol? Y N

Review of Systems

Do you currently have any of these problems?

	YES	NO	If "Yes" Please Explain
Constitution (developmental disabilities, cancer, fatigue syndrome)	☐	☐	_____
Ear/Nose/Throat (hearing loss, sinusitis, dry mouth, other)	☐	☐	_____
Neurological (MS, epilepsy, cerebral palsy, tumor, stroke, migraine, other)	☐	☐	_____
Psychiatric (depression, anxiety, bipolar, attention deficit, other)	☐	☐	_____
Cardiovascular (hypertension, stroke, heart disease, vascular disease congestive heart failure, other)	☐	☐	_____
Respiratory (smoker, asthma, bronchitis, emphysema, chronic obstruction, sleep apnea, other)	☐	☐	_____
Gastrointestinal (Chron's, colitis, ulcer, acid reflux, Celiac, other)	☐	☐	_____
Genitourinary (kidney disease, prostate disease/cancer, STD, other)	☐	☐	_____
Musculoskeletal Arthritis, fibromyalgia, muscular dystrophy, Osteoarthritis, gout, osteoporosis, other)	☐	☐	_____
Integumentary (Eczema, rosacea, Psoriasis, cold sores Herpes Zoster/shingles)	☐	☐	_____
Endocrine (Diabetes, thyroid dysfunction, hormonal dysfunction)	☐	☐	_____
Hematologic (anemia, ulcer, cholesterol, other)	☐	☐	_____
Pregnant (List any problems)	☐	☐	_____
Eyes (Glaucoma, Glaucoma Suspect, cataract, surgery, Macular degeneration, retinal degeneration/hole/detachment, injury, Keratoconus, dry eye, nystagmus, strabismus, amblyopia, other)	☐	☐	_____

Other Problems: _____

_____