

Welcome to Our Office

Date _____ Email Address _____
 Patient's Name _____ Age _____ Date of Birth _____ Sex: M F
 Ethnicity: Hispanic or Latino Not Hispanic or Latino Race: White/Caucasian Black/African American
 American Indian/Alaska Native Native Hawaiian/Pacific Islander Asian Some other race Two or more races
 Address _____
 Street _____ City _____ State _____ Zip _____
 Telephone (Home) (____) _____ (Work) (____) _____ (Mobile) (____) _____
 Social Security Number _____ Parent's Name (if minor) _____ Spouse's Name _____
 If Student, Grade _____ School _____ Occupation _____
 Responsible Party for Account _____ Relationship to Patient _____
 Payment Preference Cash Check Visa/MC/Discover/AmEx Do you have insurance? Yes No
 If you have insurance, please list insurance provider _____ I.D. number _____
 Who referred you to our office? _____
 Who may we contact in case of an emergency? _____ Telephone (____) _____

Eye History/Ocular Review of Systems

Approximate date of last eye examination _____ By Doctor _____
 Do you wear glasses? Yes No If yes, when were they prescribed? _____
 Do you wear contact lenses? Yes No If yes, when were they prescribed? _____
 Would you like to wear contact lenses? Yes No Have you ever worn contact lenses? Yes No
 Are you interested in refractive surgery (LASIK)? Yes No Have you ever received eye exercises? Yes No
 Do you wear sunglasses? Yes No Do you feel your vision problems occur at Distance Near Both Neither
 Do you currently have or have you ever had any of the following problems?

<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Excess Tearing/Watering	<input type="checkbox"/> Eye Pain
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Mucous Discharge	<input type="checkbox"/> Eye Infections
<input type="checkbox"/> Distorted Vision/Halos	<input type="checkbox"/> Redness	<input type="checkbox"/> Eye Injuries
<input type="checkbox"/> Loss of Side Vision	<input type="checkbox"/> Itching	<input type="checkbox"/> Eye Surgery
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Burning	<input type="checkbox"/> Retinal Detachment/Disease
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Foreign Body Sensation	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Floaters in Vision	<input type="checkbox"/> Sandy or Gritty Feeling	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Flashes of Light in Vision	<input type="checkbox"/> Eye Strain/Tired Eyes	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Twitching Eye Lids	<input type="checkbox"/> Light Sensitivity/Glare	<input type="checkbox"/> Crossed Eyes/Lazy Eye
		<input type="checkbox"/> Keratoconus

Medical History

Are you presently taking any medications (including OTC medications, hormones, supplements, or birth control)? Yes No
 If yes, please list and include dosage _____
 Do you have any allergies to medications? Yes No If yes, please list _____
 List all major injuries, surgeries, and/or hospitalizations you have had _____
 Are you pregnant and or nursing? Yes No
 Approximate date of last general health exam _____ Family Physician _____
 Address _____ Phone Number (____) _____

Family History

Please note any family history (parents, grandparents, siblings, children, aunts, uncles) for the following conditions:

Condition	Yes	No	?	Relationship to You
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please turn this sheet over and complete the other side.

Review of Systems

Do you currently or have you ever had any problems in the following areas?

System	Yes	No	?		Yes	No	?
Constitutional (fever, weight loss, gain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/Cardiovascular			
Integumentary (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears, Nose, Mouth, Throat				High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies, Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary (genitals/kidney/bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory				Bones/Joints/Muscles			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/Hematologic			
Endocrine (thyroid/other glands)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss this information with the doctor.

Employer _____ Address _____

Are you: Married Single Divorced Widowed

Do you use a computer or a tablet? Yes No

Do you drive? Yes No

What are some of your hobbies? _____

Do you smoke? Yes No If yes, type/amount/how long: _____

Have you ever smoked? Yes No If yes, type/amount/how long: _____

Do you use other tobacco products? Yes No If yes, type/amount/how long: _____

Do you drink alcohol? Yes No If yes, type/amount/how long: _____

Do you use illegal drugs? Yes No If yes, type/amount/how long: _____

Have you ever been exposed to/infected with any of the following? Gonorrhea Hepatitis HIV Syphilis None

Authorization

I certify that the above questions have been accurately answered to the best of my knowledge. I authorize the doctor to release any information including the diagnosis and the records of any treatment given to me or my dependants to third party payers and/or health practitioners. If applicable, I authorize my insurance company to pay directly to the doctor insurance benefits on my behalf. I understand that my insurance carrier may pay less than the actual bill for services and may not cover some tests or procedures. I agree to be ultimately responsible for payment of services rendered to me or my dependants.

Signature of Patient (or parent if minor)

Date

Doctor's Signature

O.D.

Date