

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ SSN: \_\_\_\_\_  Male  Female  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Family MD: \_\_\_\_\_  
In case of an emergency, contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_ **How did you hear about our practice?** \_\_\_\_\_  
Are you:  Employed  Retired Employer's Name: \_\_\_\_\_  
Occupation (Present or Past if Retired): \_\_\_\_\_ Work Phone: \_\_\_\_\_  
\_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Have you ever been diagnosed with or treated for any of the following? (Circle Y or N)**

- |                                       |  |
|---------------------------------------|--|
| Y / N Cataract                        | Y / N Macular Degeneration                                       |
| Y / N Glaucoma                        | Y / N Diabetic Eye Disease                                       |
| Y / N Trauma/Injury                   | Y / N Lazy Eye/Amblyopia   |
| Y / N Corneal Problem                 | Y / N Have you ever had eye surgery?<br>If yes, what type? _____ |
| Y / N Retinal Tear/Detachment         |  |
| Y / N Diabetes _____ years            | Y / N Cancer Type: _____   |
| Y / N High Blood Pressure _____ years | Y / N Kidney Disease/Kidney Stone/Liver Disease/Hepatitis        |
| Y / N Heart Attack/Heart Disease      | Y / N Arthritis  |
| Y / N Lung Disease                    | Y / N Rheumatoid Arthritis                                       |
| Y / N Neurologic: Stroke              | Y / N Gastrointestinal Problems, Colitis                         |
| Y / N AIDS/HIV                        | Y / N Thyroid Disorder   |
| Y / N Abnormal Bleeding               | Y / N Are you pregnant or is there a possibility you might be?   |

**Do you currently have: (Circle Y or N)**

- |                                  |                                       |
|----------------------------------|---------------------------------------|
| Y / N Fever/Chills               | Y / N Seizures                        |
| Y / N Ear, Nose, Throat Problems | Y / N Muscle Weakness                 |
| Y / N Chest Pain/Angina          | Y / N Numbness                        |
| Y / N Poor Circulation           | Y / N Swollen Glands                  |
| Y / N Persistent Cough           | Y / N Anemia                          |
| Y / N Shortness of Breath        | Y / N Significant weight loss or gain |
| Y / N Skin Rash or Lesions       | Y / N Environmental Allergies         |

**ALLERGIES TO MEDICATIONS:** \_\_\_\_\_

**Family History of:** Y / N Glaucoma Y / N Macular Degeneration Y / N Retinal Detachment  
**Do you:** Y / N Drink Alcohol Y / N Smoke (\_\_\_ packs per day)

<b>OFFICE USE ONLY</b>	
Pertinent Medical & General Surgery History:	Ocular History:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Current Medications:	
_____	
_____	