Patient Information

Gender _____ Title _____ Patient Date of Birth ____/____/_____

Patient Name _____
Last First Middle

Patient Address _____
Street City State Zip

Patient Home Phone _____ Patient Work Phone _____ ext. _____

Patient Cell Phone _____ Last 4 Digits of SSN ☐☐☐☐

Primary Care Provider: _____ PCP Phone: _____ PCP Fax: _____

Email _____ Employer _____

Patient Communications: *How do you prefer to receive appointment reminders?*

Email ☐ Text ☐ Phone ☐

Insurance Information ***Patients must provide insurance card prior to exam.***

Type of Insurance _____ Relationship to Subscriber _____

Subscriber's Name _____ DOB _____ Ins ID # _____

Please list all **current medications**, including eye drops and non-prescription medications, in the space below.
Please list all **allergies to medications or foods, and seasonal allergies** in the space below.
Please list dates and type of **surgery, including eye surgery**, in the space below.

Please indicate **if you (the patient) or a family member (parent, grandparent, brother, sister) ever had the following conditions.**	Patient		Family Member	
	Yes	No	Yes	No
01. Amblyopia, crossed or lazy eye?				
02. Cataracts?				
03. Eye infection?				
04. Eye injury?				
05. Glaucoma?				
06. Macular degeneration?				
07. Cardiovascular problems (high blood pressure, high cholesterol, heart disease, arrhythmia, cancer, etc.)?				
08. Endocrine problems (diabetes, high/low thyroid, cancer, etc.)?				
09. Neurological problems (stroke, numbness, weakness, headaches, paralysis, seizures, cancer, etc.)?				
10. Ear, nose, mouth/throat problems (hearing loss, sinus problems, sore throat, cancer, etc.)?				
11. Gastrointestinal/liver problems (heartburn, abdominal pain, cirrhosis, hepatitis, cancer, etc.)?				
12. Genital/urinary problems (discharge, pain, blood in urine, cancer, etc.)?				
13. Blood or lymph problems (anemia, leukemia, HIV/AIDS, cancer, etc.)?				
14. Skin problems (rashes, excessive dryness, non-healing sores, cancer, etc.)?				
15. Musculoskeletal problems (muscle aches, joint pain, swollen joints, arthritis, cancer, etc.)?				
16. Psychiatric problems (depression, anxiety, etc.)?				
17. Respiratory problems (wheezing, cough, asthma, tuberculosis, bronchitis, cancer, etc.)?				
18. Autoimmune diseases (Lupus, Crohn's disease, etc.)?				
19. Recent fever for more than 10 days, unexpected weight loss or gain, fatigue?				
20. Other conditions not mentioned above?				
21. Do you currently smoke, or have you ever smoked?				