

Date _____

Name of Patient _____ Married _____ Single _____ Widowed _____ Divorced _____

Date of Birth _____ Sex _____ Home Phone _____

Address _____ City _____ State _____ Zip Code _____

Apt. _____

Social Security No. _____ Business Phone _____

Driver's License No. _____ Cell Phone # _____

Email: _____ How did you hear about our office? _____

Person Responsible for Bill _____ Referred By _____

Employer (Name and Address) _____

Occupation: _____

Name of Spouse or Parents _____

Person to Notify for Emergency _____ Phone No. _____

Primary care physician and/or Referring Physician's Name _____

NAME AND ADDRESS OF PHARMACY _____

MEDICAL HISTORY: PLEASE EXPLAIN THE YES ANSWERS ON THE DOTTED LINE **Yes No**

Do you have any drug allergies? Please list _____

Have you had any surgery? Please list _____

.....

Are you currently on medication? Please list _____

.....

.....

.....

Have you had any eye surgery or disease before? Please list _____

.....

Are you allergic to any known materials resulting in hives, asthma, eczema, etc..... _____

Have you ever had a serious accident or injury?..... _____

Do you have diabetes?..... _____

Do you have high blood pressure?..... _____

Do you use cigarettes/tobacco? Yes/No Alcohol? Yes/No Other Substances? Yes/No

Please list the Vision/Eye problem(s) that you are experiencing or that you would like the ophthalmologist to address.

Have you ever had any serious illness or diseases involving the following? **Yes No**

Bladder..... _____

Extremities..... _____

Joints..... _____

Nervous System..... _____

Kidneys..... _____

Bleeding Disorder..... _____

Lungs..... _____

Heart..... _____

Stomach/Intestines..... _____

Skin..... _____

List any other medical conditions that you are being treated for _____
