Patient Information Form

Today's Date_______________

Patient's Full Name: ___________________________________Age:___ Date of Birth: ________
Sex: __M___F___

Address: ____
__________________ _____________________________________ Zip Code: ___________

Home Number: (___)_____________ Cell Number:(___)_____________

Additional Number: (___)________________

Emergency Contact Name: __________________ Phone Number: (___)_________________

Patient Occupation: ____________________ Patient Employer: _______________________
Retirement Date: ________________ Patient Social Security #:__________________________

Spouse's Name: ____________________ Spouse's Occupation: _________________________

Spouse's Social Security Number: ___________________________

Primary Insured Name: ___________________ Primary Insured Date of Birth:______________

Primary Insured Social Security #:______________ Relationship to Patient: ______________
Primary Insured Employer Name: ____

Medical Insurance Primary: _______________________ ID#:_______________________

Secondary: _______________________ ID#:_______________________

Vision Insurance Primary: _______________________ ID#:_______________________

Secondary: _______________________ ID#:_______________________

HISTORY AND PHYSICAL EVALUATION

NAME:________________________ AGE:______ DATE OF EXAM:__________________

FAMILY PHYSICIAN:________________________CITY/STATE:________________________

Do you have, or have you ever been treated for the following:

	YES	NO	COMMENTS
HIGH BLOOD PRESSURE	___	___	________________
DIABETES	___	___	________________
THYROID DISORDER	___	___	________________
HIGH CHOLESTEROL	___	___	________________
CANCER	___	___	________________
AFIB	___	___	________________
HEART DISEASE	___	___	________________
STROKE	___	___	________________
COPD/ASTHMA/EMPHYSEMA	___	___	________________
TUBERCULOSIS	___	___	________________
HEPATITIS	___	___	________________
MULTIPLE SCLEROSIS	___	___	________________
LUPUS	___	___	________________
RHEUMATOID ARTHRITIS	___	___	________________
SKIN DISORDERS	___	___	________________
BLOOD DISORDERS	___	___	________________
SLEEP APNEA	___	___	________________
MIGRAINES	___	___	________________
SEIZURES/EPILEPSY	___	___	________________
AIDS/HIV+	___	___	________________
CURRENTLY PREGNANT OR NURSING	___	___	________________
Any current health conditions not listed above?	___	___	________________
EYE INJURIES	___	___	________________
EYE SURGERIES	___	___	________________
EYE FOREIGN BODY REMOVALS	___	___	________________
FLASHES AND FLOATERS	___	___	________________
KERATOCONUS OR CORNEA PROBLEMS	___	___	________________
CATARACTS	___	___	________________
MACULAR DEGENERATION	___	___	________________
GLAUCOMA	___	___	________________

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Patient Name____________________ Date of Exam________________

	YES	NO	COMMENTS
DIABETIC RETINOPATHY	___	___	___
UVEITIS/IRITIS	___	___	___
OPTIC NEURITIS	___	___	___
LAZY EYE/AMBLYOPIA/STRABISMUS	___	___	___
Are you allergic to any medications?(list)	___	___	___
Do you take blood thinners?	___	___	___

Please list any other medications you are taking____________________

Any known FAMILY history of:

	YES	NO	COMMENTS
GLAUCOMA?	___	___	___
MACULAR DEGENERATION?	___	___	___
RETINAL DETACHMENT?	___	___	___
KERATOCONUS?	___	___	___

	YES	NO	
DO YOU SMOKE?	___	___	amount?___
DID YOU USED TO SMOKE?	___	___	amount?___
DO YOU DRINK ALCOHOL?	___	___	amount?___

CURRENT OCCUPATION____________________

MARITAL STATUS(Married/Single/Divorced/Widowed)____________________

==================PATIENTS: DO NOT WRITE BELOW THIS LINE=====================

UPDATED	UPDATED	UPDATED	UPDATED
DATE___	DATE___	DATE___	DATE___
INITIAL___	INITIAL___	INITIAL___	INITIAL___
INFO___	INFO___	INFO___	INFO___
DATE___	DATE___	DATE___	DATE___
INITIAL___	INITIAL___	INITIAL___	INITIAL___
INFO___	INFO___	INFO___	INFO___
DATE___	DATE___	DATE___	DATE___
INITIAL___	INITIAL___	INITIAL___	INITIAL___
INFO___	INFO___	INFO___	INFO___