Patient Information Form

Circle/Fill in all applicable.

Name:_____Prefers to be called:_____

Address:_____City_____State____Zip_____

Date of Birth:_____ Sex:_____ Primary Language:_____

Race: (American Indian, African American, Caucasian, Decline to Answer) Other:_____

Ethnicity: (Hispanic, Non-Hispanic)

Phone: Fill in all applicable, and choose one as a preferred line.

Home: ( )- - Preferred Line O

Cell: ( )- - Preferred Line O -- Can we text this number? (Yes/No)

Work: ( )- - Preferred Line O

E-mail address:_____

Insurance/Payment Plan:_____Ins. Number/SSN:_____

Responsible Party (Owner of the plan): _____birth date _____

Do you wear corrective lenses? (Glasses, Contacts, Both, No)

Are you currently wearing corrective lenses? (Glasses/Contacts/No)

Please state the patient's **Height:**_____**Weight:**_____

Patient History

Please **circle** any conditions that **the patient** currently suffers from, or circle "none"

Constitution: **Sleep Apnea**, Fever (Currently). Other:_____ (None)

Cardiovascular: **High Cholesterol**, **High Blood Pressure**, **Stroke**. Other:_____(None)

E.N.M.T.: Hearing Problems, Dry Mouth, Dizziness. Other:_____(None)

Respiratory: **Asthma**, **COPD**, **Sarcoidosis**. Other:_____(None)

Gastrointestinal: Stomach/Intestinal Problems/ **Crohn's Disease**. Other:_____(None)

Genitourinary: Dialysis, Kidney Problems. Other:_____(None)

Musculoskeletal: **Arthritis**, **Lupus**, **M.S**., **Myasthenia Gravis**. Other:_____(None)

Integumentary: Rashes, **Rosacea**. Other:_____(None)

Neurological: **Epilepsy, Seizures, Migraines**. Other:_____(None)

Psychiatric: Alzheimer's, **Anxiety**, **Depression**, Bipolar. Other:_____(None)

Endocrine: **Diabetes Type 1, Diabetes Type 2, Graves Disease, thyroid** Other:_____(None)

If you are a diabetic, who is your doctor?_____

Hematologic: Anemia/Sickle Cell, Taking Blood Thinners Other_____(None) *Immunologic:* HIV/AIDS, Suppressed Immune System. Other:_____(None)

Has the patient ever been diagnosed with:

Cataracts? (Yes/No)Surgery? date_____

Glaucoma? (Yes/No)

Retinal Tear/Damage? (Yes/No)

Have you been diagnosed with any other eye-related injury? (Yes/No) If so, what?_____

Are you a smoker? (Current Smoker, Former Smoker, Never)

Family History

Please **mark** all that are known to affect the **family** of the patient.

O Cataracts
O Macular degeneration
O Glaucoma
O Other Retinal Disorders
O Eye turn/strabismus &/or Amblyopia/lazy eye
O Arthritis
O Cancer
O Diabetes
O other Endocrine Disease/thyroid
O Stroke
O High Cholesterol
O Cardiovascular/heart disease
O High Blood Pressure

Medications

In the space below, please list, if any, the medications the patient is currently taking.
If possible, include mode of induction (pills, inhaler, etc) and dosage.

_____
_____
_____
_____
_____
_____

Please list any drug allergies: _____

_____

Please list any other allergies (seasonal, food, etc.): _____