**GENERAL INFORMATION:**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip\_\_\_\_\_\_\_\_
Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Age\_\_\_\_\_ Sex\_\_\_\_ Height\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_ Flu Shot? Y / N
Home Phone: ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_\_
PRIMARY CARE PHYSICIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Race: **(CIRCLE)** American Indian/Alaska Native, Asian, Black/African American, Hispanic/Latino,

 Native Hawaiian or Other Pacific Islander, White, Decline Information
Ethnicity: **(CIRCLE)** Hispanic/Latino, Not Hispanic/Latino, Decline Information

Preferred Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Responsible Party (if under 18)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Name of primary cardholder: (if different from patient)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ DOB: \_\_\_ /\_\_\_ / \_\_\_\_\_
Home Phone: ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR VISIT:** (Please Circle)

Do you wear glasses? Y/N Have you been prescribed bifocals? Y/N Are the glasses working? Y/N

Have you worn contacts? Y/N Are your contacts working? Y/N Are you interested in contacts? Y/N

**MEDICAL HISTORY:** (Your personal)
**SYSTEMIC:** (Circle any that apply)
Diabetes Fatigue Syndrome Headaches Herpes Simplex Pacemaker
Sjogren’s Disease Hearing Loss Cancer Arthritis Shingles

High Blood Pressure Sinusitis Hormonal Dysfunction COPD Anemia
Heart Disease Multiple Sclerosis Sleep Apnea Colitis Lupus
Rheumatoid Arthritis Thyroid Dysfunction Ankylosing Spondylitis Ulcer Autism
Vascular Disease Depression Elevated Cholesterol Osteoporosis Muscular Dystrophy
Coronary Artery Disease Attention Deficit Acid Reflux Gout Stroke/CVA
Emphysema Anxiety Disorder Celiac Disease Bronchitis Psoriasis
Crohn’s Disease Bipolar Disorder Kidney Disease Prostate Disease Eczema Migraines Asthma STD Rosacea Epilepsy

**OCULAR:** (Circle any that apply)
Cataracts Dry Eye Retinal Defects Watering Sensitivity to Light
Macular Degeneration Eye Infection/Allergy Retinal Degeneration Discharge Poor Night Vision
Glaucoma Floaters/Flashes Redness Blurred Vision Double Vision
Diabetic Retinopathy Iritis or Uveitis Burning/Itching Eye Strain/Eye Pain Total Loss of Vision

**SURGICAL HISTORY:** (EYE Surgeries ONLY)
Procedure Date Performed Doctor
1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL HISTORY: (CIRLCE YES AND ALL family members who apply, OR NO)**
Cancer Y / N Father Mother Brother Sister Son Daughter UnknownDiabetes Y / N Father Mother Brother Sister Son Daughter UnknownHypertension Y / N Father Mother Brother Sister Son Daughter Unknown
Hyperthyroidism Y / N Father Mother Brother Sister Son Daughter UnknownHypothyroidism Y / N Father Mother Brother Sister Son Daughter Unknown
**FAMILY OCULAR HISTORY: (CIRLCE YES AND ALL family members who apply, OR NO)**
Cataracts Y / N Father Mother Brother Sister Son Daughter Unknown
Macular Degeneration Y / N Father Mother Brother Sister Son Daughter Unknown
Glaucoma Y / N Father Mother Brother Sister Son Daughter Unknown
 **SOCIAL HISTORY:**Do you use Alcohol? Yes / No / Formerly How Often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you use Tobacco? Yes / No / Formerly Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you use Illegal Drugs? Yes / No / Formerly
 **ALLERGIES:**Seasonal Allergies Y/N *(if yes, circle one)* Mild Moderate Severe
Food Allergies Y / N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Drug Allergies: Y / N
1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 **MEDICATIONS:
\_\_\_\_ I DO NOT TAKE ANY MEDICATIONS

Please list ALL medications you are currently taking**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage (mg)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage (mg)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage (mg)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage (mg)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage (mg)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage (mg)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage (mg)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage (mg)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage (mg)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CONSENT AND RECEIPT OF PRIVACY PRACTICES (HIPPA)**

**(**To be completed by **ALL PATIENTS** or parent/guardian if patient under 18)

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires that all health care records and other individually identifiable health information used or disclosed to us in any form, be kept confidential. The federal law gives you significant rights to understand and control how your information is used. As required by HIPPA, we have prepared an explanation, which is attached, describing how we are required to maintain the privacy of your health information. I also understand that I may revoke this consent by written request at any time. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent. By signing this I acknowledge that I have read the attached document and understand its contents.

Signature (patient or parent/guardian)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_