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	Unknown
Diabetes Y / N	Father	Mother	Brother	Sister	Son	Daughter	Unknown
Hypertension Y / N	Father	Mother	Brother	Sister	Son	Daughter	Unknown
Hyperthyroidism Y / N	Father	Mother	Brother	Sister	Son	Daughter	Unknown
Hypothyroidism 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:_____________