**Patient Information**

First Name: \_\_ Middle Initial: \_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_

Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: ❍ American Indian ❍ Asian ❍ African American ❍ Native Hawaiian ❍ Other \_\_\_\_\_\_\_\_\_\_\_\_\_ ❍ Unknown ❍ White

Ethnicity: ❍ Hispanic ❍ Non-Hispanic ❍ Unknown Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? ❍ Physician Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❍ Internet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❍ Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❍ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your visit today injury related? ❍ No ❍ Yes Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place: ❍ Home ❍ School ❍ Work ❍ Other

Claim # (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information**

What is the main reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation (if retired, list occupation prior to retirement): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Computer Use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hours per day

Do you wear glasses? ❍ No ❍ Yes

Do you wear contacts? ❍ No ❍ Yes, brand: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often do you change the lenses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use lubricating eye drops? ❍ No ❍ Yes, frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Physical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone or Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete both sides.**

**Health Information (cont.)**

Please check the appropriate box to indicate whether you now have, or have ever had, any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| ❍ Diabetes | ❍ Rosacea | ❍ Gout | ❍ Bleeding |
| ❍ High blood pressure | ❍ Thyroid disease | ❍ Macular degeneration | abnormalities |
| ❍ Irregular heartbeat | ❍ Arthritis | ❍ Singles/Zoster | ❍ Sinus problems |
| ❍ Stroke | ❍ Hepatitis | ❍ MRSA | ❍ Hearing loss |
| ❍ Cancer | ❍ HIV | ❍ Tuberculosis | ❍ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ❍ Hay Fever/Seasonal Allergies | ❍ Glaucoma | ❍ Auto-immune disease | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please check the appropriate box for **any current symptoms:**

|  |  |  |  |
| --- | --- | --- | --- |
| ❍ Weight loss/Gain | ❍ Chest pain | ❍ Excessive hunger/thirst | ❍ Excessively dry skin |
| ❍ Fatigue | ❍ Irregular heartbeat | ❍ Numbness | ❍ Muscle aches |
| ❍ Hearing loss | ❍ Abdominal pain | ❍ Weakness | ❍ Joint pain |
| ❍ Sinus problems | ❍ Diarrhea/vomiting | ❍ Headaches | ❍ Environmental allergies |
| ❍ Shortness of breath | ❍ Urinary pain | ❍ Depression/anxiety | ❍ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ❍ Wheezing | ❍ Blood in urine | ❍ Rashes | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

If you have diabetes, please check: ❍ Type 1 ❍ Type 2 Onset Year: \_\_\_\_\_ Last HgA1c: \_\_\_\_\_\_ Last Blood Sugar: \_\_\_\_\_\_\_

Endocrinologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalizations and/or Previous Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do any of your relatives have: ❍ Glaucoma ❍ Retinal Detachment ❍ Macular Degeneration ❍ Diabetes ❍ Blindness

❍ Cataracts ❍ N/A, Adopted

If yes, please list family member(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Medication Allergies |
|  |
|  |
|  |
|  |
| ❍ Latex ❍ No known allergies |

|  |  |  |
| --- | --- | --- |
| Medications | Dosage (mg) | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Tobacco Use: ❍ Smoking ❍ Chewing ❍ Never ❍ Former: ( \_\_\_\_ yr quit) ❍ Current: ( \_\_\_\_ # of yrs) ( \_\_\_\_ # per day)

Have you had an injury from a fall in the last year OR have you had more than 2 falls during the past year? ❍ No ❍ Yes

Do you feel lightheaded or unsteady when you stand up or walk? ❍ No ❍ Yes

Do you use a wheelchair? ❍ No ❍ Yes If yes, can you transfer to another chair unassisted? ❍ No ❍ Yes

Patient Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_