PATIENT INFORMATION

PERSONAL INFORMATION

Name ____ Date ______________________

Date of Birth _____________ Age ___ M / F ___ Social Security No. ___________________

Address _________________________________City_______________State_____Zip_______

Phone: Home __________________ Work __________________ Mobile ______________

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Occupation _______________________ Employer ____________________________________

Driver's License Number _____________________ Email _______________________________

Medicare and Private Insurance now require the next five items to be completed with your information or enter the word "Declined." Weight ___________ Height ___________

Race _______________ Preferred Language _________________ Ethnicity ________________

EMERGENCY CONTACT ____________________ Relationship _____________ Phone ___________

REFERRED BY: ____

COMMERCIAL INSURANCE INFORMATION - PRIMARY INSURED IF SAME AS ABOVE

Name of Insured _____________________________ Relationship ______________________

Date of Birth _______________ Social Security No. _________________________________

Address ____ Home Phone ______________

City ________________________ State __________________ Zip ___________________

Employer ________________________ Business Phone _____________________________

COMMERCIAL INSURANCE (This must be completed unless you intend to pay privately)

Insurance Company ____________________________ Subscriber I.D. # ________________

Group # ________________

Phone: ________________ Address ___________________________________

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MEDICARE / MEDICAID INSURANCE

Medicare # ________________

Group # _______________

Supplemental Insurance Co. _________________________ Subscriber I.D. # _______________

Phone: _______________

Medicaid # ________________________________

I. Please describe the reason for your visit today.

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FAMILY HISTORY

II. One of the Meaningful Use requirements for using an Electronic Health or Medical Record is to include the details of your Family History. Please enter the diseases and disorders that have occurred in your immediate family. That includes your grandparents, parents, siblings and children.

Disease/Disorder	Relationship

III. Do you take any medications? YES ❑ NO ❑ If, YES, please list names, frequency and amounts:

IV. Do you have any medication or food allergies? YES ❑ NO ❑ If, YES, please list:

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V. Have you ever smoked? YES ❑ NO ❑ If, YES, how much currently? ________________________

If you have stopped, when? ____________________________

VI. Alcohol? YES ❑ NO ❑ If, YES, how much? ____

Please complete the following fillable pages of your past and current history by placing a "✔" mark in each box that describes your symptoms, medical problems, ocular history and review of systems. Use the *Additional Details* lines on page 6 to enter any explanatory text.

Chief Complaint (what is your problem?)

- ❑ vision change
- ❑ blurry vision
- ❑ broken blood vessel
- ❑ bump on eyelid
- ❑ burning sensation
- ❑ cataract
- ❑ chemical burn
- ❑ chronic irritation
- ❑ cloudy vision
- ❑ contact lens irritation
- ❑ cyst on eyelid
- ❑ diabetes
- ❑ difficult with small print
- ❑ discharge (matter)
- ❑ distorted vision
- ❑ double vision
- ❑ dryness
- ❑ eyes tire easily
- ❑ failed driver's test
- ❑ film over eye
- ❑ flashes of light
- ❑ floaters
- ❑ fluctuating vision
- ❑ foreign body sensation
- ❑ freckle
- ❑ glare from lights
- ❑ glasses problem
- ❑ glaucoma
- ❑ glaucoma suspect
- ❑ gritty feelings
- ❑ growth on eye
- ❑ hard to focus
- ❑ headache
- ❑ injury
- ❑ iritis
- ❑ irritation
- ❑ itching
- ❑ keratoconus
- ❑ lids stuck together
- ❑ light sensitive
- ❑ long-term risk medicine
- ❑ macular degeneration
- ❑ macular pucker
- ❑ migraines
- ❑ ocular hypertension
- ❑ pain in or around eye
- ❑ plaquenil use
- ❑ poor night vision
- ❑ redness
- ❑ routine exam
- ❑ school request
- ❑ second opinion
- ❑ shingles
- ❑ skim over vision
- ❑ stye
- ❑ swelling
- ❑ tearing
- ❑ trouble driving at night
- ❑ twitching of eyelid
- ❑ veil or cloud in field of vision
- ❑ ____________
- ❑ ____________
- ❑ ____________

Medical History ❑ All Negative ❑ Declines

- ❑ ADD
- ❑ acid reflux
- ❑ acne
- ❑ allergies
- ❑ alzheimer's
- ❑ anemia
- ❑ anxiety
- ❑ arthritis
- ❑ asthma
- ❑ autoimmune disorder
- ❑ bell's palsy
- ❑ bleeding tendency
- ❑ blood disorder
- ❑ cancer
- ❑ central nervous system
- ❑ cholesterol elevated
- ❑ cluster headache
- ❑ colitis
- ❑ depression
- ❑ diabetes type I
- ❑ diabetes type II
- ❑ diverticulitis
- ❑ drug allergies
- ❑ eczema
- ❑ fibromyalgia
- ❑ gout
- ❑ hand tremor
- ❑ heart disease
- ❑ hepatitis
- ❑ herniated disc
- ❑ hypertension
- ❑ irregular heart rate
- ❑ kidney stones
- ❑ lupus erythematosus
- ❑ melanoma
- ❑ migraines
- ❑ multiple sclerosis
- ❑ neuropathy
- ❑ osteoporosis/osteopenia
- ❑ parkinsonism
- ❑ plaquenil therapy
- ❑ prostate problem
- ❑ psoriatic arthritis
- ❑ respiratory problems
- ❑ rheumatoid arthritis
- ❑ rosacea
- ❑ sarcoidosis
- ❑ seizure disorder
- ❑ shingles
- ❑ shortness of breath
- ❑ sjoegren's syndrome
- ❑ sleep apnea
- ❑ spine disc compression
- ❑ surgery
- ❑ swelling
- ❑ thyroid trouble
- ❑ TIA (transient ischemic attack)
- ❑ tuberculosis
- ❑ ulcerated colon
- ❑ ulcers
- ❑ ____________
- ❑ ____________
- ❑ ____________

Previous Ocular History ❑ All Negative

❑ amblyopia
❑ astigmatism
❑ baggy eyelids
❑ blepharitis
❑ blindness
❑ cataract
❑ conjunctivitis
❑ color blind
❑ contact lens wear
❑ corneal problem
❑ cranial nerve palsy
❑ crossed eyes
❑ diabetic retinopathy
❑ double vision
❑ dry eyes
❑ elevated eye pressure
❑ farsighted
❑ flashes of light
❑ foreign body
❑ freckle in eye
❑ glaucoma
❑ glaucoma suspect
❑ hereditary eye condition
❑ intraocular lens surgery
❑ iritis
❑ keratitis
❑ keratoconus
❑ lasik
❑ macular degeneration
❑ macular pucker
❑ migraines
❑ nearsighted
❑ night vision problem
❑ ocular migraine
❑ presbyopia (cannot read)
❑ pterygium
❑ ptosis (droopy eyelid)
❑ punctum (tearduct) plugs
❑ recurrent erosion
❑ radial keratotomy (RK)
❑ retinal problem
❑ shingles
❑ strabismus (crooked eye)
❑ stye
❑ tearing
❑ injury/trauma
❑ vitreous detachment
❑ wear contacts
❑ wear glasses
❑ ____________
❑ ____________

Cardiology ❑ All Negative

❑ ankle swelling
❑ atrial fibrillation
❑ by-pass surgery
❑ chest pain
❑ cholesterol elevated
❑ congestive heart failure
❑ enlarged heart
❑ heart disease
❑ heart murmur
❑ heart valve replacement
❑ high blood pressure
❑ irregular heartbeat
❑ mitral valve prolapse
❑ obstructive sleep apnea
❑ pacemaker
❑ palpitations
❑ poor circulation
❑ rheumatic fever
❑ shortness of breath
❑ stents
❑ supraventricular tachycardia
❑ syncope (fainting)
❑ ____________
❑ ____________

Ear, Nose, Mouth and Throat History ❑ All Negative

❑ congestion
❑ cough (dry)
❑ cough with sputum
❑ dentures
❑ dry throat/mouth
❑ dysphagia (swallowing diff)
❑ ear disorder
❑ hard of hearing
❑ head injury
❑ hoarseness
❑ jaw claudication
❑ meniere's disease
❑ nosebleeds
❑ plugged ears
❑ poor dentistry
❑ runny nose
❑ sinus problems
❑ sore throat
❑ sore teeth
❑ ____________
❑ ____________

Endocrine ❑ All Negative

❑ depression
❑ diabetes type I
❑ diabetes type II
❑ diabetes type II - insulin
❑ excessive sweating
❑ Grave's disease
❑ hair loss
❑ hyperthyroidism
❑ hypoglycemia
❑ hypothyroidism
❑ obesity
❑ pancreatitis
❑ pituitary problem
❑ postmenopausal
❑ thyroid problem
❑ weight gain
❑ weight loss
❑ ____________

Gastrointestinal ❑ All Negative

❑ acid reflux
❑ barrett's esophagitis
❑ black tarry stools
❑ bloating
❑ change in stool color
❑ colitis
❑ constipation
❑ crohn's disease
❑ diarrhea
❑ diverticulitis
❑ food intolerances
❑ gastroparesis
❑ gerd
❑ heartburn
❑ hemorrhoids
❑ hiatal hernia
❑ indigestion
❑ irritable bowel syndrome
❑ lazy bowel
❑ liver trouble
❑ nausea
❑ use of laxatives
❑ ulcer
❑ vomiting

Genitourinary ❑ All Negative

❑ blood in urine
❑ change in frequency
❑ dsyuria (discomfort)
❑ female disorders
❑ genital discharge
❑ hesitancy
❑ high frequency of urination
❑ high volume of urination
❑ impotence
❑ incontinence
❑ kidney disease, chronic
❑ kidney problems
❑ kidney stones
❑ kidney transplant
❑ male disorders
❑ nocturia (night urination)
❑ prostate cancer
❑ prostate enlargement
❑ urgency
❑ veneral disease
❑ ____________

Hematologic/lymphatic ❑ All Negative

❑ anemia
❑ bleeding tendencies
❑ blood clots
❑ blood disorders
❑ blood dyscrasia
❑ bruising tendencies
❑ chr lymphocytic leukemia
❑ hemochromatosis
❑ high blood calcium
❑ hepatitis B
❑ lymphadenopathy
❑ monoc gamm of unk sig
❑ platelet disorder
❑ sickle cell anemia
❑ thalassemia

Integumentary ❑ All Negative

❑ acne
❑ birth marks
❑ cancer
❑ change in hair or nails
❑ change in pigmentation
❑ cold sores of lips
❑ dandruff
❑ dry skin
❑ dryness
❑ eczema
❑ foot sores
❑ fungus infection
❑ herpes simplex
❑ lichen planis
❑ lumps
❑ other lesions
❑ poison ivy rash
❑ pruritis (itching)
❑ psoriasis
❑ rosacea
❑ seborrhea
❑ shingles (herpes zoster)
❑ skin rash
❑ ____________

Muculoskeletal ❑ All Negative

❑ arthritis
❑ claudication (intermittent)
❑ cramps
❑ deep vein thrombosis
❑ gout
❑ fibromyalgia
❑ osteoarthritis
❑ osteopenia
❑ osteoporosis
❑ pain
❑ psoriatic arthritis
❑ rheumatoid arthritis
❑ scleroderma
❑ sjoegren's syndrome
❑ swelling
❑ systemic lupus erythematosus
❑ varicosities
❑ ____________

Neurological ❑ All Negative

❑ alzheimer's
❑ bell's palsy
❑ blackouts
❑ brain tumor
❑ cluster headaches
❑ dementia
❑ dizziness
❑ fainting
❑ forgetfulness
❑ guilain barré
❑ local weakness
❑ migraine headaches
❑ neurodermatitis
❑ numbness
❑ paralysis
❑ parkinsonism
❑ poor coordination
❑ poor memory
❑ proximal muscle weakness
❑ restless leg syndrome
❑ seizures
❑ speech difficulty
❑ stroke
❑ tingling of extremities

Psychiatric ❑ All Negative

❑ anxiety
❑ attention deficit disorder
❑ bipolar
❑ dementia
❑ depression
❑ eating disorder
❑ manic-depressiveness
❑ nervousness
❑ neuroses
❑ poor memory
❑ psychoses
❑ schizophrenia
❑ sleeping difficulty
❑ suicidal ideation
❑ tension

Respiratory ❑ All Negative

❑ asthma
❑ emphysema
❑ chronic bronchitis
❑ chronic cough
❑ chr obstruct pulmonary dis
❑ cough
❑ cough (dry)
❑ dyspnea on exertion
❑ orthopnea
❑ reactive airways
❑ shortness of breath
❑ sleep apnea
❑ tuberculosis
❑ ____________
❑ ____________

Constitutional Symptoms ❑ All Negative

❑ fever
❑ headache
❑ jaw claudication
❑ malaise
❑ night sweats
❑ scalp tenderness
❑ weakness
❑ weight gain
❑ weight loss

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Additional Details