PATIENT DEMOGRAPHICS

Date: _____ Full legal name: _____

Nick name? _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

e-mail: _____ @ _____

Preferred Contact Phone #: _____

Alternate Phone #: _____

HIPAA PRIVACY:
Please list any family or friends you wish to grant access to your medical records (optional).

Name	Relationship
_____	_____
_____	_____

INSURANCE INFO:

Insurance Company	ID Number / Group Number	Subscriber name/DOB	Last 4 Digits SSN#

AFFORDABLE CARE ACT/MEANINGFUL USE QUESTIONS:

Race:

- ☐ Asian
- ☐ Black/African American
- ☐ Greek
- ☐ Hispanic or Latino (All Races)
- ☐ Indian
- ☐ Jamaican
- ☐ Multi-Racial
- ☐ Native American Indian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Decline to Specify

Language Preference:

- ☐ English
- ☐ American Sign Language
- ☐ Chinese
- ☐ French
- ☐ German
- ☐ Polish
- ☐ Russian
- ☐ Spanish
- ☐ Ukrainian
- ☐ Vietnamese

Ethnicity:

- ☐ Latino or Hispanic
- ☐ Not Latino or Hispanic
- ☐ Decline to Specify

HEALTH HISTORY

Date: _____ Nickname: _____

Name: _____ DOB: _____

DO YOU WEAR CONTACT LENSES? ☐ Yes ☐ No

Local Pharmacy (name/location) _____

Mail Order Pharmacy: _____

EYE MEDICATIONS (Please list all)	
Medication Name	Dosage
Eye Vitamins (AREDS, Macular Degen.) ☐ Yes ☐ No	Artificial Tears? ☐ Yes ☐ No

OTHER MEDICATIONS (Please list all)		
Medication Name	Strength	Dosage

Aspirin? ☐ Yes ☐ No Insulin? ☐ Yes ☐ No Ever Used Flomax or other prostate med? ☐ Yes ☐ No

ALLERGIES (Please list your allergies) ☐ **No Known Medical Allergies**	
Latex (allergy or sensitivity)? ☐ Yes ☐ No	
Allergy	Reaction

PAST EYE HISTORY / EYE SURGERY	**YEAR**

LIST YOUR PAST MEDICAL DIAGNOSES

Diabetes Type	☐ Yes	☐ No	COPD or Emphysema	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Type of Cancer?		
Asthma	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No

Continued on next page...

PAST SURGERIES	YEAR

FAMILY HISTORY OF EYE DISEASE			FAMILY MEMBER
Glaucoma	☐ Yes	☐ No	
Macular Degeneration	☐ Yes	☐ No	
Strabismus or Lazy Eye	☐ Yes	☐ No	

REVIEW OF SYSTEMS Check every symptom that you have **TODAY**

Constitutional:		Neurological:	
Fever	☐ Yes	Dizziness	☐ Yes
Weight Loss	☐ Yes	Numbness of extremities	☐ Yes
Head (HEENT):		Psychiatric:	
Sinus Problems	☐ Yes	Depressed Mood	☐ Yes
Sore Throat	☐ Yes	Emotional Changes	☐ Yes
Respiratory:		Integumentary/Skin:	
Cough	☐ Yes	Rash	☐Yes
Shortness of Breath (Dyspnea)	☐ Yes	Ulcer	☐ Yes
Cardiovascular:		Musculoskeletal:	
Arrhythmia (heart rhythm problem)	☐ Yes	Muscle Cramping	☐ Yes
Irregular heart beat/palpitations	☐ Yes	Muscle Weakness	☐ Yes
Gastrointestinal:		Hematologic/Lymphatic:	
Abdominal Pain	☐ Yes	Bleeding	☐ Yes
Nausea	☐ Yes	Tender Lymph Nodes	☐ Yes
Genitourinary:		Immunologic:	
Painful Urination (Dysuria)	☐ Yes	Food Allergies	☐ Yes
Sudden Urge to Urinate (urgency)	☐ Yes	Seasonal Allergies	☐ Yes
Metabolic/Endocrine:			
Heat Intolerance	☐ Yes		
Frequent Drinking/Thirst (Polydipsia)	☐ Yes		

DOCTOR INFORMATION (include clinic name and city)	
Primary Care Dr:	Other Dr(s) you would like to receive exam info:
Referred by Dr:	
Optometrist:	

SOCIAL HISTORY	
Have you ever used tobacco? ☐ Yes ☐ No/Never ☐ Unknown	
Smoking Status:	Non-Smoking Tobacco Use (chew/snuff/dipping):
☐ Never smoked	☐ Never used
☐ Former Smoke	☐ Ex-user of chew/snuff/dip
☐ Current every-day smoker	☐ Chews tobacco
☐ Current some-day smoker	☐ Snuff user

PATIENT NAME: _____

DOB: _____