Patient Demographics/Ocular History

Full Name: ______________________________ Birth Date: _____/_____/_____

Address: ______________________________ SSN: ______________________________

Occupation: ______________________________ Cell Phone: ______________________________

Employer: ______________________________ Work Phone: ______________________________

Medical Doctor: ______________________________ Medical Insurance: ______________________________

Vision Insurance: ________VSP _____Davis _______EyeMed _______Spectera _______Medicaid

Primary Card Holder Name/DOB/SSN: ____________________/____________________/____________________

Responsible Party if different: ______________________________ Relationship to Patient: ______________________________

Phone: ______________________________ Billing Address if different: ______________________________

How did you hear about us?: ________Radio ________Online Search ________Newspaper ________Social Media

________Referral/Name of Person who Referred: ______________________________

How may we contact you for appointment reminders? (Circle all that apply): email cell home text mail

Have you ever been diagnosed with any of the following conditions:

	Yes	No		Yes	No
Cataract	☐	☐	*Eye Infection, allergy*	☐	☐
Macular Degeneration	☐	☐	*Floaters and/or Flashes*	☐	☐
Glaucoma	☐	☐	*Iritis or Uveitis*	☐	☐
Diabetes	☐	☐	*Retina Defects or Degenerations*	☐	☐
Diabetic Retinopathy	☐	☐	*Lazy Eye or Eye Turn*	☐	☐
Dry Eye	☐	☐	*Other*	☐	☐

Are you having any of the following eye concerns:

	Yes	No		Yes	No
Redness	☐	☐	*Eye Pain*	☐	☐
Burning	☐	☐	*Severe Sensitivity to Lights*	☐	☐
Itching	☐	☐	*Headache*	☐	☐
Tearing	☐	☐	*Poor night vision*	☐	☐
Discharge	☐	☐	*Bothersome night glare*	☐	☐
Blurred Vision	☐	☐	*Double Vision*	☐	☐
Eyestrain	☐	☐	*Total Loss of Vision*	☐	☐

Signature: ______________________________ Date: _____/_____/_____

Medical History

Please check the box beside any problem you currently have, or have had, in the following area

CONSTITUTIONAL
- ☐Fever ☐All normal
- ☐Weight Loss/Gain

EARS, NOSE, MOUTH, THROAT
- ☐Sinus Congestion ☐All normal
- ☐Dry Throat/Mouth

NEUROLOGICAL
- ☐Migraines ☐All normal
- ☐Dizziness
- ☐Seizures
- ☐Stroke

PSYCHIATRIC
- ☐Anxiety ☐All normal
- ☐Depression
- ☐Memory Loss
- ☐Hallucinations

CARDIOVASCULAR / CARDIAC
- ☐Arteriosclerosis ☐All normal
- ☐Heart Disease
- ☐High Blood Pressure
- ☐High Cholesterol

RESPIRATORY
- ☐Asthma ☐All normal
- ☐Bronchitis
- ☐Emphysema
- ☐Chronic Cough

GASTROINTESTINAL
- ☐Diarrhea / Constipation ☐All normal
- ☐Ulcers
- ☐Reflux
- ☐IBS/Crohn's Disease

GENITOURINARY
- ☐Kidney Disease ☐All normal
- ☐Ovarian / Uterine Cancer
- ☐Prostate Cancer

MUSCULOSKELETAL
- ☐Rheumatoid Arthritis ☐All normal
- ☐Muscle Pain
- ☐Joint Pain

INTEGUMENTARY (Skin)
- ☐Cancer ☐All normal
- ☐Rashes
- ☐Easy Bruising

ENDOCRINE
- ☐Diabetes ☐All normal
- ☐Thyroid Disease
- ☐Chronic Fatigue

HEMATOLOGIC / LYMPHATIC
- ☐Anemia ☐All normal
- ☐Bleeding Problems
- ☐Breast Cancer

ALLERGIC / IMMUNOLOGIC
- ☐Allergy / Hay Fever ☐All normal

List any medications you are currently taking (including oral contraceptives, aspirin, over the counter medications):
____

____

Are you allergic to any medications? ☐No ☐Yes If yes, which ones? ________________________________

List all major surgeries and/or hospitalizations you have had:
____

Do you smoke or use smokeless tobacco?____________________How much/day?____________________________________

Do you drink alcohol?_____________________________How much?____

Do you use recreational drugs? ____________________

Height:______________________Weight:_____________________

FAMILY HISTORY Please note family history (parents, grandparents, siblings, children; living or deceased) :

	RELATION TO YOU		RELATION TO YOU
☐Cancer	____________	☐Cataract	____________
☐Diabetes Type I	____________	☐Macular Degeneration	____________
☐Diabetes Type II	____________	☐Glaucoma	____________
☐Hypertension	____________	☐Heart Disease	____________
☐Hyperthyroidism	____________	☐Hypothyroidism	____________

Signature: ____ Date: ______/______/______