

PATIENT INFORMATION

Legal Name: _____
Goes By: _____
Address: _____
City/State/Zip: _____
Home Phone: _____
Daytime Phone: _____
Birthday: _____ Age: _____
Social Security #: _____

Please Circle:
Male Female
Single Married Divorced Widowed
Employed FT/PT Self Employed
Student Retired Other

Employer: _____
Occupation: _____
Primary Care Physician: _____
CURRENT MEDICATIONS: _____

GUARANTOR (Person Financially Responsible and/or Primary Insured (circle)

SELF / SPOUSE / PARENT / OTHER
If other, list relation: _____
Legal Name: _____
Address: _____
City/State/Zip: _____
Home Phone: _____
Daytime Phone: _____
Birthday: _____
Social Security #: _____
Employer: _____
Insurance Provider: _____

ALLERGIES TO MEDICATIONS: _____
Have you been experiencing any fever or weight loss? If yes, explain: _____

Please check any of the conditions you have currently or have had in the past:

EYES:

___ Blurry Vision ___ Burning ___ Discharge ___ Double Vision
___ Flashing Lights ___ Itching ___ Floaters ___ Cataract
___ Eye Surgery ___ Glaucoma ___ Night Blindness ___ Eye Muscle Problems
___ Retina Problems ___ Other
Explain: _____

EAR, NOSE, THROAT, MOUTH:

___ Hearing Problems ___ Post Nasal Drip ___ Sinus Congestion ___ Chronic Cough
___ Runny Nose ___ Dry Throat/Mouth ___ Other
Explain: _____

CARDIOVASCULAR:

___ High Blood Pressure ___ Heart Attack ___ Chest Pain ___ Congestive Heart Failure
___ Carotid Artery Disease ___ Surgery ___ Mitral Valve Prolapse
Explain: _____

RESPIRATORY:

___ Asthma ___ Emphysema ___ Tuberculosis ___ Lung Cancer
___ Surgery ___ Other
Explain: _____

GASTROINTESTINAL (stomach/intestines)

___ Jaundice/Hepatitis ___ Ulcers Bleeding ___ Hiatal Hernia ___ Cancer
___ Surgery ___ Other
Explain: _____

GENITOURINARY (genital/bladder/kidney)

Pregnant Now Kidney Disease Prostate Cancer Cervical/Ovarian Cancer
 Surgery Sexually Transmitted Disease Other
Explain: _____

INTEGUMENTARY (skin/breast)

Skin Disease/Cancer Breast Disease/Cancer Other
Explain: _____

MUSCULO-SKELETAL

Rheumatoid Arthritis Degenerative Arthritis Lupus
 Cancer Other
Explain: _____

NEUROLOGICAL

Fainting/Dizziness Migraines Benign Tumor Convulsions/Seizures
 Stroke/Paralysis Alzheimer's Myasthenia Gravis Other
Explain: _____

PSYCHIATRIC

Depression Schizophrenia Other
Explain: _____

HEMATOLOGIC/LYMPHATIC

Anemia Bleeding Disorder Cancer Sickle Cell Disease
 Leukemia Other Explain: _____

ALLERGIC/IMMUNOLOGIC

Seasonal Hay Fever Immune Problems General Allergies
 Other Explain: _____

ENDOCRINE:

Diabetes Thyroid Problems Hormone Other
Explain: _____

SOCIAL HISTORY

Drugs Alcohol Smoking Recent Voyages

PAST HISTORY:

Please describe any other problems, illnesses, surgeries or medications that were not mentioned above:

FAMILY HISTORY:

Please describe any major illnesses or hereditary problems of parents, grandparents, brothers/sisters:

It is the patient's responsibility to provide current and accurate medical and vision insurance benefits and card prior to and at the time of service. If such is not provided at that time, it will become the patient's responsibility to receive reimbursement from the insurance carrier.

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____