PATIENT INFORMATION FORM

NAME: _____ DATE: _____

STREET ADDRESS/P.O. BOX: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____ MOBILE PHONE: _____ WORK PHONE: _____

EMAIL: _____ DATE OF BIRTH: _____ AGE: _____

EMPLOYER/SCHOOL: _____ OCCUPATION/GRADE: _____

HOW WERE YOU REFERRED TO OUR OFFICE: _____

REASON FOR VISIT: _____

DATE OF LAST EYE EXAM: _____ DATE OF LAST MEDICAL EXAM: _____

PARENT/GUARDIAN (IF MINOR): _____

NAME OF SPOUSE (IF MARRIED): _____

EMERGENCY CONTACT (NAME & PHONE): _____

PRIMARY CARE PHYSICIAN: _____

LIST ALL MEDICATIONS WITH DOSAGES THAT YOU CURRENTLY TAKE: _____

_____

_____

_____

MEDICATION ALLERGIES: _____

DO YOU SMOKE: _____ IF SO, HOW MUCH: _____

ETHNICITY/RACE: _____ PREFERRED LANGUAGE: _____

PLEASE CHECK ALL THAT APPLY TO YOU:

- ☐ GLAUCOMA
- ☐ CATARACTS
- ☐ EYE INJURIES
- ☐ EYE SURGERY
- ☐ HEADACHES
- ☐ DOUBLE VISION
- ☐ BLURRY VISION
- ☐ DRY EYES
- ☐ ITCHY EYES
- ☐ MACULAR DEGENERATION
- ☐ EYE PAIN
- ☐ DIABETES
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HEART DISEASE
- ☐ DIGESTIVE DISORDERS
- ☐ KIDNEY DISEASE
- ☐ THYROID DISEASE
- ☐ CANCER
- ☐ HIV
- ☐ ALLERGIES/SINUS
- ☐ SLEEP APNEA
- ☐ COLOR BLIND
- ☐ SURGERIES (LIST)

_____

_____

_____

- ☐ OTHER:

_____

_____

_____

_____

_____

PLEASE CHECK ALL THAT APPLY TO YOUR IMMEDIATE FAMILY:

- ☐ GLAUCOMA
- ☐ CATARACTS
- ☐ MACULAR DEGENERATION
- ☐ DIABETES
- ☐ COLOR BLIND
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ EYE SURGERY
- ☐ CANCER
- ☐ OTHER

_____

_____

HOW DO YOU INTEND TO PAY: CHECK: _____ CASH: _____ BANK CARD: _____ INSURANCE: _____

PATIENT SIGNATURE: _____ DATE: _____