Patient History and Information

Name: _____ Age_____ Birthdate_____

Home Address _____ Home Phone_____

_____ Cell Phone_____

E-Mail Address_____ Social Security#_____

Occupation: _____ Hobbies: _____

Primary Language_____ Race_____ Ethnicity_____

Primary Doctor:(Not Group) _____

Address_____

_____

Would you like us to send a report to your doctor? Y / N (If yes, Please supply complete address above)
Whom may we thank for referring you?_____
Insurance Name and Address: _____
_____

Insurance Subscriber Name & Birthdate_____

Medical:

	Self	Family (Relation)
Constitution (Insomnia/Weight Loss)	_____	_____
Cardiovascular (Blood Pressure; Heart Dis.)	_____	_____
Ears, Nose, Mouth, Throat	_____	_____
Respiratory (Asthma, COPD)	_____	_____
Gastrointestinal (Hepatitis, Crohn's)	_____	_____
Genitourinary (Kidney Stones, Dialysis)	_____	_____
Musculoskeletal (Arthritis, MS)	_____	_____
Psychiatric (Dementia, Alzheimer's)	_____	_____
Integumentary (Skin Cancer)	_____	_____
Neurological (Bell's palsy, Epilepsy)	_____	_____
Endocrine (Diabetes, Thyroid)	_____	_____
Hematologic (Anemia, Leukemia)	_____	_____
Allergic/Immunologic (HIV, Lupus)	_____	_____
Other_____	_____	_____

Eyes:

	Self	Family (Relation)
Glaucoma	_____	_____
Cataracts	_____	_____
Macular Degeneration	_____	_____
Eye Injury	_____	_____
Retinal Disease	_____	_____
Other Disease	_____	_____
Blindness	_____	_____
Strabismus (eye turn)	_____	_____
Diabetes	_____	_____
Dry Eye	_____	_____
Refractive	_____	_____
Other _____	_____	_____

Are you taking any Medications now? Y / N Names: _____

Are you allergic to any medications? Y/ N Names: _____

Cigarette/tobacco use? Current/Former/Never Do you drink alcohol? Y / N

Do you take recreational drugs? Y / N Names: _____

Signature_____ **Date**_____

Parent/Legal Guardian must sign for patients under 18