Welcome

Many insurers, including Medicare are mandating this or similar forms. We appreciate your cooperation!

Last Name _____ First Name _____ MI _____ Age _____ Birthdate _____

Who may we thank for referring you? _____

Personal Physician Name: _____ Physician Number: (___) _____

Do you have any medication allergies? Y N

Please list. _____

Are you taking any medications? Y N

Please list. _____

Have you had any serious eye disease, injuries, or surgeries? (Glaucoma, Cataract, etc.) Y N

Family History

Glaucoma? Y N

Macular Degeneration? Y N

Other (list) Y N

Do you smoke? Y N

Medical Problems not listed below:

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	Y	N	Fainting Spells	Y	N	Sinus Problems	Y	N
Alcohol/Drug Abuse	Y	N	Frequent Headaches	Y	N	Stroke	Y	N
Alzheimers/Dementia	Y	N	Hay Fever	Y	N	Thyroid Problems	Y	N
Anemia	Y	N	Heart Attack (date_____)	Y	N	Tuberculosis	Y	N
Arthritis	Y	N	Heart Murmur	Y	N	Ulcers	Y	N
Artificial Joints/Valves	Y	N	Heart Surgery (date_____)	Y	N			
Arrhythmia	Y	N	Hepatitis	Y	N			
Asthma	Y	N	Herpes/Fever Blisters	Y	N			
Auto Immune Disease	Y	N	High Blood Pressure	Y	N			
Blood Transfusion	Y	N	HIV/AIDS	Y	N			
Cancer/Chemotherapy	Y	N	Kidney Problems	Y	N			
Colitis	Y	N	Liver Disease	Y	N			
Congential Heart Defect	Y	N	Low Blood Pressure	Y	N			
COPD	Y	N	Mitral Valve Prolapse	Y	N			
Defibrillator	Y	N	Pacemaker	Y	N			
Depression	Y	N	Psychiatric Issues	Y	N			
Diabetes	Y	N	Radiation Treatment	Y	N			
Difficulty Breathing	Y	N	Seizures	Y	N			
Elevated Cholesterol	Y	N	Shingles	Y	N			
Epilepsy	Y	N	Sickle Cell Disease	Y	N			

I attest the information I have given is correct to the best of my knowledge. I also understand this information is held in the strictest confidence and that it is my responsibility to notify this office of any changes.

_____
Patient Signature Date

Reviewed and Updated:

Patient Initials: _____ Date _____

Patient Initials: _____ Date _____

Patient Initials: _____ Date _____

Patient Initials: _____ Date _____

Patient Initials: _____ Date _____