WELCOME TO OUR OFFICE

PLEASE PRESENT MAJOR MEDICAL INSURANCE CARDS TO THE RECEPTIONIST.

Please Print.

Date _____ Gender_____
Patient's Full Legal Name _____
DOB _____/_____/_____ SSN# _____/_____/_____
Address _____
City/St _____ Zip _____ Country___
Type of Address □ Home □ Work
Home Phone _____
Cell Phone _____
Work Phone _____
Email _____
Note: It is now required that we obtain an email address so we can upload your visit to the patient portal.

Marital Status □ M □ S □ D □ W
If married, spouse's name _____
Spouse's DOB _____/_____/_____

Primary Language □ English □ Spanish □ _____
Race □ White □ African American □ Asian
□ Other _____ □ Decline to Answer
Ethnicity □ Hispanic/Latino □ Non-Hispanic/Latino
□ Unknown □ Decline to Answer
Last Eye Exam _____/_____/_____ ☐ Here (on file)
Your Family Doctor's Name _____
Preferred Pharmacy _____

MISCELLANEOUS

Are you Pregnant/Breastfeeding? □ Yes □ No
Any Special Needs? _____
Were you Referred to our office? □ Yes □ No
If yes, by whom?_____
Have you previously seen any of our doctors?
□Dr. Jennifer Compton □Dr. Harvey Schleter □ Dr. Bill Robinson
Occupation _____
Employer _____
Hobbies/Recreational Activities you enjoy _____
How many hours a day do you use a computer? _____

Do you wear glasses? □ Yes □ No
Do you wear contact lenses? □ Yes □ No
If not, are you interested in contact lenses? □ Yes □ No
Are you interested in refractive surgery? □ Yes □ No
Do you have trouble reading signs at night? □ Yes □ No
Are you bothered by glare from:
Overhead lighting? □ Yes □ No
A computer screen? □ Yes □ No
Oncoming headlights? □ Yes □ No
Are you sensitive to sunlight? □ Yes □ No

REVIEW OF SYSTEMS Please circle if you <u>currently have</u> any of the following problems or conditions:

Constitutional
- Fever
- Weight Loss
- Weight Gain

Cardiovascular
- Irregular Heartbeat
- Faintness

Ear/Nose/Mouth/Throat
- Partial Hearing Loss
- Total Hearing Loss
- Pain When Swallowing
- Toothache
- Dry Mouth
- Cold Sores

Respiratory
- Shortness of Breath
- Wheezing

Gastrointestinal
- Reflux
- Anorexia
- Ulcer

Genito-Urinary
- Kidney Disease*

Musculoskeletal
- Joint Pain
- Muscle Pain
- Stiffness

Integumentary (Skin)
- Bruising
- Excessive Dryness

Neurological
- Headache
- Migraines
- Limb Weakness
- Numbness

Psychiatric
- Anxious
- Confused
- Trouble Remembering Things

Endocrine
- Mood Swings
- Excessive Sweating
- Thinning of Hair

Hematologic (Blood)
- Anemia
- Bleeding Disorder*

Allergic/Immunologic
- Pain in Lymph Nodes
- Swelling of Lymph Nodes
- Auto-Immune Disorder*

If marked with a (*), please describe the condition or provide the exact diagnosis: _____
_____
_____

Other Condition/Symptoms Not Listed: _____
_____
_____

MISCELLANEOUS
Do you have an implantable device?
□ No
□ Yes (Type _____)
Do you have a living will?
□ No
□ Yes

OCULAR HISTORY Please circle if you have or have had any of the following:

Age-Related Macular Degeneration	Cataracts	Strabismus (Crossed Eyes)
Amblyopia (Lazy Eye)	Glaucoma	Retinal Detachment
Blindness (One Eye)	Keratoconus	Dry Eye Syndrome
Blindness (Both Eyes)	Retinopathy	Eye Injury _____

Other Condition Not Listed Above: _____

PAST MEDICAL HISTORY Please circle if you've been diagnosed with any of the following:

Acquired Immune Deficiency Syndrome (AIDS)	COPD	Human Immunodeficiency Virus (HIV)
Anxiety	Dementia	Thyroid Disorder
Rheumatoid Arthritis	Diabetes	High Cholesterol
Osteoarthritis	Mental Disorder	High Blood Pressure
Asthma	Stroke	Seasonal Allergies
Cancer (Please specify _____)	Sleep Apnea	Heart Disease

Other Condition Not Listed Above:_____

FAMILY HEALTH HISTORY Please mark if your family has/had any of these. If yes, please note which family member.

		Family Relation			Family Relation
Macular Degeneration	□No □Yes	_____	Arthritis	□No □Yes	_____
Amblyopia (Lazy Eye)	□No □Yes	_____	Cancer	□No □Yes	_____
Blindness	□No □Yes	_____	Stroke	□No □Yes	_____
Glaucoma	□No □Yes	_____	Diabetes	□No □Yes	_____
Retinal Disorder	□No □Yes	_____	Heart Disease	□No □Yes	_____
Strabismus (Crossed Eyes)	□No □Yes	_____	Other Condition		_____

SOCIAL HISTORY

Do you use recreational drugs? □No □Yes

Do you drink alcohol? □No □Yes

TOBACCO USE

□ Never smoker □ Light smoker

□ Former smoker □ Current everyday smoker

HEIGHT _____ **WEIGHT** _____ □ I decline to disclose this information.

SURGERY Please list any surgeries below.

General Surgeries: _____

Eye Surgeries:_____

MEDICATIONS

We can now automatically pull your prescriptions into our system electronically, saving you the time and energy of recording them!

If you do <u>not</u> wish to use this feature, please check below:

□ I prefer to list my medications manually. Do not transfer them.

Medications_____

_____

_____

□ I take no medications at this time.

MEDICATION ALLERGIES

□ No Medication Allergies

□ I am allergic to the following:

_____

_____

_____

Patient Signature _____Date _____/_____/_____

*****PEDIATRIC PATIENTS OR FOR THOSE PATIENTS WHO ARE UNDER GUARDIANSHIP OF ANOTHER INDIVIDUAL*****

If patient is a minor or not his or her own guardian, please <u>print</u> list guardian's name and contact number:

Name _____ Phone Number _____

Guardianship Type □Biological Parent □Foster/Adoptive Parent □Stepparent □Other_____

If you are accompanying this patient to his/her exam, but are not their guardian, list your name:

Name _____ Relationship _____