Passaro Eyecare Inc.

727-848-2020

Please print the history forms and give directly to Passaro Eyecare Inc. Staff. DO NOT MAIL!

Passaro Eyecare Inc.

Patient Name:_____ Date_____Chart Number_____

Patient: _____ Spouse: _____
Last Name First Name M Name

SSN: ___-___-___ Birthdate: ___-___-___ Sex: ____ Race: _____
Month Day Year M/F

Permanent Address : _____
Street

_____ Home Phone: (____)_____
City State Zip

Secondary Address: _____
Street

_____ Home Phone: (____)_____
City State Zip

E-mail Address: _____ Cell Phone: (____)_____

☑ I agree to receive email communications from St. Luke's.

Employer: _____ Address: _____
Name Street

_____ Phone: (____)_____
City State Zip

IN CASE OF AN EMERGENCY,
PLEASE CONTACT: _____ Phone: (___)_____
Name Relationship

INSURANCE INFORMATION

1st Insurance: _____
Name Policy Number Subscriber's Name

Address: _____
Street City State Zip

2nd Insurance: _____
Name Policy Number Subscriber's Name

Address: _____
Street City State Zip

PRIMARY CARE/FAMILY PHYSICIAN: _____ Phone: (___)_____
Name

Address: _____
Street City State Zip

PREFERRED PHARMACY: _____ Phone: (____)_____
Name

WHAT PROBLEMS ARE YOU HAVING WITH YOUR EYES? _____

_____

HOW DID YOU HEAR ABOUT US? _____

WERE YOU REFERRED OR RECOMMENDED BY A DOCTOR?

Doctor: _____ Address: _____
Name Street

_____ Phone: (____)_____
City State Zip

Passaro Eyecare Inc.

Patient Name:_____ Date_____Chart Number_____

MEDICAL HISTORY

PLEASE PRINT. PLEASE DO NOT MAIL

Patient: _____ Age: ____ Marital Status: M S D W
Last Name First Name M

Address: _____
Street City State Zip

Phone: (_____)_____ Family Doctor: _____
Name

Date of Last Visit: _____ Reason for Visit: _____

Tests Performed (please list): _____

PAST OCULAR HISTORY:

Previous History of Eye Treatment or Exams: _____

_____

What problems are you having with your eyes? _____

PAST MEDICAL HISTORY: Please check No or Yes for each of the following.

No	Yes		No	Yes		No	Yes		No	Yes	
☐	☐	Rheumatic Fever	☐	☐	Heart Disease	☐	☐	Diabetes	☐	☐	Anemia
☐	☐	Pneumonia	☐	☐	Angina	☐	☐	Liver Disease/Hepatitis	☐	☐	Bleeding Problems
☐	☐	Tuberculosis	☐	☐	Irregular Heartbeat/Pacer	☐	☐	Kidney Disease	☐	☐	Blood Diseases
☐	☐	Asthma	☐	☐	Heart Attack	☐	☐	Hiatal Hernia	☐	☐	Radiation/Chemo
☐	☐	Emphysema	☐	☐	Congestive Heart Failure	☐	☐	Ulcers	☐	☐	Memory Loss
☐	☐	Bronchitis	☐	☐	Stroke	☐	☐	Diverticulosis	☐	☐	Alzheimer's
☐	☐	Carotid Artery Disease	☐	☐	Claustrophobia	☐	☐	Arthritis	☐	☐	Psychiatric Disorder
☐	☐	High Blood Pressure	☐	☐	Thyroid Disorder	☐	☐	Phlebitis	☐	☐	Seizures
									☐	☐	MRSA
									Other _____		

HAVE YOU OR A FAMILY MEMBER BEEN DIAGNOSED WITH THE FOLLOWING?

No	Yes		No	Yes	
☐	☐	Creutzfeldt-Jakob Disease	☐	☐	Fatal Familial Insomnia
☐	☐	Gerstmann-Straussler-Scheinker Disease	☐	☐	Have you ever received injections of hormones to increase your height?

HOSPITALIZATIONS: Please list the date of any relevant surgeries or hospitalizations.

No	Yes		No	Yes		No	Yes	
☐	☐	Eye Surgery _____	☐	☐	Stomach/Abdomen _____	☐	☐	Cancer _____
☐	☐	Thyroid/Neck _____	☐	☐	Gallbladder _____	☐	☐	Prostate _____
☐	☐	Heart _____	☐	☐	Appendectomy _____	☐	☐	Hysterectomy _____
☐	☐	Lungs _____	☐	☐	Hernia _____	Other _____		
☐	☐	Mastectomy _____	☐	☐	Back _____	Other _____		

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Patient Name:_____ Date:_____Chart Number_____

PRESENT PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS:

Please list name, dose and frequency. _____

_____

_____

ALLERGIES TO MEDICATIONS: ☐ No Known Allergies Latex Sensitivity: No ☐ Yes ☐

_____

_____

FAMILY HISTORY:

	Living? No	Living? Yes	Medical Problems or Cause of Death
Mother	☐	☐	_____
Father	☐	☐	_____
Sister/Brother	☐	☐	_____

Please list any history of eye disease or eye surgery in your family: _____

_____

SOCIAL HISTORY: Do (Did) you:

No	Yes	Former			
☐	☐	☐	Smoke	How much per day? _____	For how many years? _____
☐	☐	☐	Drink Alcohol	How much per day? _____	
☐	☐	☐	Recreational Drug Use	How much per day? _____	

REVIEW OF SYSTEMS: Do you have these now? If yes, circle condition and explain.

No	Yes		
☐	☐	**Skin:** Psoriasis/Rash/Shingles	_____
☐	☐	**Head:** Headache/Migraines/Temporal Arteritis	_____
☐	☐	**Eyes:** Cataract/Glaucoma/Retina	_____
☐	☐	**Ears:** Hearing Loss/Aids	_____
☐	☐	**Nose/Mouth/Throat:** Dentures/Sinus	_____
☐	☐	**Neck:** Restriction of Movement/Difficulty swallowing	_____
☐	☐	**Pulmonary:** Cough/Shortness of Breath/Wheeze	_____
☐	☐	**CV:** Chest Pain/Palpitations	_____
☐	☐	**GI:** Ulcers/Pain	_____
☐	☐	**MS:** Leg Cramps/Swelling	_____
☐	☐	**Neuro:** Tremor/Speech Problems	_____
☐	☐	**Psych:** Anxiety/Depression/Insomnia/Panic Attacks	_____