PATIENT DATA
Harper Optometric Care

TODAY'S DATE:______________________________

PATIENT NAME:____
Last First Middle Initial

ADDRESS:____
Street Address

____
City State Zip

____
Billing Address- If different

____
City State Zip

PHONE: ____________________ ____________________ ____________________
Home ☐ Cell ☐ Work ☐
(Check box for preferred phone number.)

EMAIL:____

DATE OF BIRTH:___________________________

RACE:
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Pacific Islander

ETHNICITY:
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other:_______________________

FAMILY DOCTOR:____

Address:____

Phone:_____________________________ Fax:______________________________________

PREFERRED PHARMACY:____

Address____

REFERRED TO OUR OFFICE BY:____

PATIENT MEDICAL HISTORY
Harper Optometric Care

TODAY'S DATE:____________________________

PATIENT NAME:____
Last First Middle Initial

Do you have problems with any of these body systems?

- Gastrointestinal (ulcers, digestive, reflux) Y/N?
- Ear/Nose/Throat (sinus) Y/N?
- Respiratory (asthma, COPD) Y/N?
- Mental (memory, depression) Y/N?
- Blood (cholesterol, anemia) Y/N?
- Immunological (Lupus, Crohn's) Y/N?
- Nervous (Parkinson's, Alzheimer's, MS) Y/N?
- Genitourinary (prostate, kidney, bladder) Y/N?
- Musculoskeletal (arthritis, osteoporosis) Y/N?
- Skin (basal/squamous cell carcinoma) Y/N?
- Endocrine (thyroid, other glands) Y/N?
- Constitutional (fever, weight loss/gain) Y/N?

Do you or members of your family have?

	PERSONAL	FAMILY	
Hypertension (high blood pressure)	Y/N?	Y/N?	________________
Heart Disease (heart attack, blockage, irregular beats)	Y/N?	Y/N?	________________
Vascular Disease (stroke, TIA, poor circulation)	Y/N?	Y/N?	________________
Diabetes Mellitus (Type 1 or Type 2)	Y/N?	Y/N?	________________
Date of Onset________________			
Glaucoma	Y/N?	Y/N?	________________
Date of Onset________________			
Macular Degeneration	Y/N?	Y/N?	________________
Cataract	Y/N?	Y/N?	________________
Amblyopia (lazy eye)	Y/N?	Y/N?	________________
Strabismus (eye turn)	Y/N?	Y/N?	________________

Have you had any eye operations? Y/N ____

Have you had any eye injuries? Y/N ____

Major surgeries? Y/N ____

Other medical problems? Y/N ____

Do you drive? Y/N
Do you use tobacco products? Y/N
Former smoker? Y/N
Do you drink alcohol? Y/N
Occupation? ____
Retired? Y/N

Are you allergic to any medications? Y/N ____

PLEASE LIST ALL CURRENT MEDICATIONS ON BACK SIDE (or provide a list to be copied)