

PATIENT INFORMATION

Today's Date: _____

Name _____ Date of birth: ____/____/____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Home Phone _____

Social Security # _____ Male Female Work Phone _____

E-mail _____ Married Single Occupation _____

May we contact you by email? No Yes Partnered Widowed Employer _____

May we speak to anyone else about your health care? No Yes (if more than one person, please let us know)

Person: _____ Relationship: _____ Phone: _____

Vision plan carrier and contract # _____ None

Medical insurance carrier and contract # _____ None

Name on insurance card: _____ Birthdate: _____ Relationship to patient: _____

Medical History - Please note it is our policy to dilate all first-time patients

Are you diabetic? No Yes

List ALL medications you take (including over-the-counter medications, aspirin, and oral contraceptives):

Do you have any allergies to medication? No Yes If yes, list: _____

List all major injuries, surgeries, and hospitalizations that you have had: _____

List any of the following that you have had – crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections or eye injuries: _____

If female, are you pregnant and/or nursing? No Yes

Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____

Do you wear contacts? No Yes If yes, how old is your present pair of lenses? _____

Brand of contacts _____ Are they comfortable? No Yes

Family History

Please note any family history (parents, grandparents, siblings, children) for the following conditions:

Disease/Condition	No	Yes	Relationship
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Name _____ Date ____/____/____

Social History - This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes If yes, please describe: _____

Do you use tobacco products? No Yes If yes, type/amount/how long _____

Do you drink alcohol? No Yes If yes, type/amount/how long _____

Do you use illegal drugs? No Yes If yes, type/amount/how long _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you currently, or have you ever had, any problems in the following areas:

	No	Yes	?		No	Yes	?
Constitutional				Ear, Nose, Mouth, Throat			
Fever, weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies, Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary				Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory			
Eyes				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/Cardiovascular			
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular disease/cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones/Joints/Muscles			
Glare/Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic infection of eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/Hematologic			
Flashes/Floaters in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems			
Endocrine				Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature: All of the above is true to my knowledge. I may have a copy of this office's Privacy Policy if I wish.

Patient or Guardian: _____ Date: _____

Jennifer Craig, OD

Doctor's Signature _____ Brian R. Pettie, OD Date _____