PATIENT INFORMATION

Name____ Today's date: ______/_______/_______

Address ____ Cell Phone ________________________

City _________________________ State _______ Zip _______ Home Phone ______________________

Date of birth: ________/_________/__________ Work Phone _______________________

E-mail ____ Occupation________________________

□Male □Female □Married □Single □Partnered □Widowed Employer_________________________

Ethnicity: □ African Descent □ Caucasian □ Hispanic □ American Indian □ Asian □ Pacific Islander □ Other

Primary medical doctor: ______________________________________ Phone #: _______________________

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 - <u>Please note it is our policy to dilate all first-time patients</u>

Are you diabetic? □No □Yes

<u>List ALL medications you take</u> (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	□	□	______________________
Cataract	□	□	______________________
Crossed Eyes	□	□	______________________
Glaucoma	□	□	______________________
Macular Degeneration	□	□	______________________
Retinal Detachment/Disease	□	□	______________________
Arthritis	□	□	______________________
Cancer	□	□	______________________
Diabetes	□	□	______________________
Heart Disease/	□	□	______________________
High Blood Pressure	□	□	______________________
Kidney Disease	□	□	______________________
Thyroid Disease	□	□	______________________
Other	□	□	______________________

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	?
Constitutional			
Fever, weight loss/gain	□	□	□
Integumentary			
Skin	□	□	□
Neurological			
Headaches	□	□	□
Migraines	□	□	□
Seizures	□	□	□
Eyes			
Loss of vision	□	□	□
Blurred vision	□	□	□
Distorted vision/Halos	□	□	□
Loss of side vision	□	□	□
Double vision	□	□	□
Dryness	□	□	□
Mucous discharge	□	□	□
Redness	□	□	□
Sandy or gritty feeling	□	□	□
Itching	□	□	□
Burning	□	□	□
Foreign body sensation	□	□	□
Excess tearing/Watering	□	□	□
Glare/Light sensitivity	□	□	□
Eye pain or soreness	□	□	□
Chronic infection of eye	□	□	□
Sties or chalazion	□	□	□
Flashes/Floaters in vision	□	□	□
Tired eyes	□	□	□
Endocrine			
Thyroid/Other glands	□	□	□

	No	Yes	?
Ear, Nose, Mouth, Throat			
Allergies, Hay Fever	□	□	□
Sinus Congestion	□	□	□
Runny Nose	□	□	□
Post-Nasal Drip	□	□	□
Chronic Cough	□	□	□
Dry Throat/Mouth	□	□	□
Respiratory			
Asthma	□	□	□
Chronic Bronchitis	□	□	□
Emphysema	□	□	□
Vascular/Cardiovascular			
Diabetes	□	□	□
Heart Pain	□	□	□
High blood pressure	□	□	□
Vascular disease/cholesterol	□	□	□
Gastrointestinal			
Chronic diarrhea	□	□	□
Chronic constipation	□	□	□
Genitourinary			
Genitals/Kidney/Bladder	□	□	□
Bones/Joints/Muscles			
Rheumatoid arthritis	□	□	□
Muscle pain	□	□	□
Joint pain	□	□	□
Lymphatic/Hematologic			
Anemia	□	□	□
Bleeding problems			
Allergic/Immunologic	□	□	□
Psychiatric	□	□	□

Patient Signature: All of the above is true to my knowledge. I also affirm that I have been given the opportunity to review this office's HIPAA privacy notice.

Patient or Guardian:______________________________ **Date:** ____________________

<u>PLEASE READ</u>: **Please sign if you give consent to be contacted by text or email regarding appointment reminders and glasses and/or contact lens prescriptions. I acknowledge that email is not a secure form of transmission, and will not hold Dr. Brian R. Pettie Eyecare, PC, or any of its employees responsible if the email intended for me is intercepted by another party.**

SIGN if you consent to be contacted by email and text messages: ______________________________