Chart # _____

PATIENT INFORMATION & MEDICAL HISTORY

Patient: _____ Date of Birth: _____ Sex: M / F

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ ** Cell: _____ Soc. Sec. No.: _____

** May we leave a message at this number for appointment reminders? ☐ Yes ☐ No **

☐ Parent *OR* ☐ Guardian: _____ Phone: _____ DOB: _____

e-Mail: _____ Employer: _____ Work Phone: _____

Optometrist: _____ Referring Doctor: _____

Primary Care Physician: _____ **Pharmacy:** _____

Spouse: _____ DOB: _____ Employer: _____

Emergency Contact: _____ Phone: _____

REVIEW OF SYSTEMS: Do you currently have any of the following? *Circle those that pertain to you.*		
Diabetes ☐ Type 1 ☐ Type 2	**Yes**	**No**
High blood pressure, arthritis, thyroid	**Yes**	**No**
Chronic fever, fatigue, weight gain/loss, epilepsy, anemia	**Yes**	**No**
Ear/nose/throat: hearing loss, sinus or throat trouble	**Yes**	**No**
Heart Problems/Disease chest pain, irregular heart beat	**Yes**	**No**
Respiratory, shortness of breath, asthma, emphysema, TB	**Yes**	**No**
Gastrointestinal, heartburn, abdominal pain, diarrhea, ulcers)	**Yes**	**No**
Urinary, pain/discomfort, blood in urine	**Yes**	**No**
Skin, rashes, excessive dryness, psoriasis	**Yes**	**No**
Musculoskeletal, muscle aches, joint pain, swollen joints	**Yes**	**No**
Neurologic, numbness, weakness, headaches, paralysis)	**Yes**	**No**
Psychiatric, depression, anxiety	**Yes**	**No**
HIV/AIDS	**Yes**	**No**
Cancer/Leukemia	**Yes**	**No**
OTHER:	**Yes**	**No**

MEDICATIONS: LIST ALL OF THE MEDICATIONS YOU ARE TAKING.

EYE DISEASES – PAST / PRESENT	**DRUG ALLERGIES**	**SURGERIES/HOSPITALIZATIONS < 5 YRS**

FAMILY HISTORY – Identify blood relatives with the following:		**SOCIAL HISTORY**
Diabetes:	**Stroke:**	**Caffeine: Yes ☐ No ☐ Quantity/wk:**
High Blood Pressure:	**Glaucoma:**	**Tobacco: Yes ☐ No ☐ Quantity/wk:**
Heart Disease:	**Macular Degeneration:**	**Pneumonia Vaccination: Yes ☐ No ☐**

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature: X _____ **Date:** _____

Reviewed on: _____	**Reviewed on:** _____	**Reviewed on:** _____	**Reviewed on:** _____	**Reviewed on:** _____
By Tech: _____	**By Tech:** _____	**By Tech:** _____	**By Tech:** _____	**By Tech:** _____
By Dr. _____	**By Dr.** _____	**By Dr.** _____	**By Dr.** _____	**By Dr.** _____