

Date: _____
 Name of Patient: _____ Date of Birth: _____
 Marital Status: (circle one) Single Married Divorced Widowed Gender: (circle one) Male Female
 Race: (Circle One) Caucasian African-American Asian Latino Other (Please Specify): _____
 Ethnicity: (Circle one) Hispanic Non-Hispanic Preferred Language: _____
 Phone: (Home) _____ (Cell) _____ (Business) _____
 Address: _____ Apt: _____
 City: _____ State: _____ Zip Code: _____
 Social Security No. _____ Driver's License / ID No. _____
 Email: _____

Person Responsible for Bill: _____
 Employer (Name and Address): _____
 Occupation: _____
 Name of Spouse or Parents: _____
 Person to Notify for Emergency: _____ Phone No. _____
 How did you hear about our office? _____

Primary care physician and/or Referring Physician's Name: _____
 Please list the Vision/Eye problem(s) that you are experiencing or that you would like the ophthalmologist to address:

Are you interested in Vision correction surgery (LASIK or Lens implant surgery) for yourself? Yes No
NAME AND ADDRESS OF PHARMACY _____

List any known **allergies** (drug, seasonal, material, food, etc.) and your **reactions** to them:
 Allergy: _____ Reaction: _____
 Allergy: _____ Reaction: _____
 Allergy: _____ Reaction: _____
 Allergy: _____ Reaction: _____
 Allergy: _____ Reaction: _____

List **medications** you are presently taking, both prescribed and over-the-counter (include **dosage** and **frequency** of use)

MEDICAL HISTORY: Please explain the "YES" answers on the dotted lines below YES NO
 Have you had any surgery? Please list _____

 Have you had any eye surgery or disease before? Please list _____

 Have you ever had a serious accident or injury?..... _____
 Do you have diabetes?..... _____
 Do you have high blood pressure?..... _____
 Height _____ Weight _____ Do you use: Alcohol? Yes / No Other Substances? Yes / No
 How frequently do you use cigarettes/tobacco? (Circle one) 1. Every day 2. Some days
 3. Former smoker 4. I have never smoked
 Have you ever had any serious illness or diseases involving the following? YES NO
 Joints..... _____
 Nervous System..... _____
 Kidneys..... _____
 Bleeding Disorder..... _____
 Lungs..... _____
 Heart..... _____
 Stomach/Intestines..... _____
 Skin..... _____
 Other _____

List any other medical conditions that you are being treated for _____
