Patient History and Information

Name: ______________________________ Age_______ Birthdate______________

Home Address ___________________________________ Home Phone___________

___________________________________Cell Phone_____________

Do you prefer to be contacted by Home phone, Cell phone; e-mail or U.S. mail? ________________

E-Mail Address__________________________ Social Security#___________________

Occupation: _______________________ Hobbies: _______________________

Primary Language__________________ Race______________________ Ethnicity_____________

Primary Doctor:(Not Group) _______________________ Address________________________

Would you like us to send a report to your doctor? Y / N (If yes, Please supply complete address above)

Whom may we thank for referring you?_______________________________________

Insurance Name and Address: ____

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Insurance Subscriber Name & Birthdate_______________________________________

Medical:	Self	Family (Relation)
Constitution (Insomnia/Weight Loss)	________	____________________
Cardiovascular (Blood Pressure; Heart Dis.)	______	____________________
Ears, Nose, Mouth, Throat	________	____________________
Respiratory (Asthma, COPD)	________	____________________
Gastrointestinal (Hepatitis, Crohn's)	________	____________________
Genitourinary (Kidney Stones, Dialysis)	________	____________________
Musculoskeletal (Arthritis, MS)	________	____________________
Psychiatric (Dementia, Alzheimer's)	________	____________________
Integumentary (Skin Cancer)	________	____________________
Neurological (Bell's palsy, Epilepsy)	________	____________________
Endocrine (Diabetes, Thyroid)	_________	____________________
Hematologic (Anemia, Leukemia)	_________	____________________
Allergic/Immunologic (HIV, Lupus)	_________	____________________
Other	_________	____________________

Eyes:	Self	Family (Relation)
Glaucoma	______	_____________
Cataracts	_______	_____________
Macular Degeneration	_____	_____________
Eye Injury	________	____________
Retinal Disease	_________	_____________
Other Disease	________	____________
Blindness	_________	____________
Strabismus (eye turn)	________	____________
Diabetes	_________	____________
Dry Eye	_________	____________
Refractive	_________	____________
Other	________	____________

Are you allergic to any medications? Y/ N Names: ________________________________

Cigarette/tobacco use? Current/Former/Never Do you drink alcohol? Y / N

Do you take recreational drugs? Y / N Names: ________________________________

Signature______________________________ **Date**____________________

Parent/Legal Guardian must sign for patients under 18