Patient Health History Intake Form

Please fill this form to the best of your knowledge. If you have any questions, please ask a team member. All information will remain confidential.

Name_____ Date of Birth_____ Today's Date_____

Address_____ City _____ State_____ Zip_____

Home phone_____ Work Phone_____ Cell phone_____

Email address_____ Medical Doctor _____

Social Security No._____ Marital Status_____ Gender_____

Occupation_____ Full time_____ Part time_____ Retired_____

How did you hear about our office:_____

Medical Insurance_____ Vision Plan_____

Eye medications (drops, vitamins, etc.)_____

Other **Medications**_____

_____

_____

Prior Eye Surgeries_____

Other Recent Surgeries_____

Do you smoke? _____ If yes, how many packs per day?_____ If yes, for how long have you smoked?_____

Do you drink alcohol?_____ If yes, how many drinks per week?_____

Do you wear glasses_____ Do you wear contact lenses_____ Type:_____

Does anyone in your **immediate** family have any of the following eye or systemic diseases? If so, please list relationship.

Glaucoma _____ High Blood Pressure_____

Macular Degeneration_____ Diabetes_____

Cataract_____ Cancer_____

Do you currently or have you previously had any problems in the following areas? If yes, please explain:

Constitution (cancer,fatigue,developmental)_____

ENT (hearing loss, sinusitis,etc)_____

Neurological (MS, CVA, Migraine, etc)_____

Psychiatric (anxiety,depression,etc)_____

Cardiovascular (heart, blood pressure,etc)_____

Respiratory (asthma, bronchitis,etc)_____

Genitourinary (bladder, prostate,etc)_____

Gastrointestinal (ulcers, acid reflux,etc)_____

Musc/skeletal (arthritis, etc)_____

Integumentary (skin, etc)_____

Endocrine (diabetes, thyroid, etc)_____

Hematologic (high cholesterol, anemia,etc)_____

Allergy (drug, environmental,other)_____