Patient Information Form

Date _____

Name _____

Address _____ City _____ State _____ Zip _____

Employer/Occupation _____

Family Physician _____ Date of Birth _____ SS# _____

Home Phone _____ Work Phone _____ Sex ❑ M ❑ F

Spouse/Mother or Father/ If female, are you pregnant? ❑ Y ❑ N Marital Satus ❑ Married ❑ Single

Guardian Name _____ Relationship _____

Vision Insurance Carrier _____ Group/Policy # _____

Primary Card Holder's Name and Birthdate _____

2nd Insurance Carrier _____ Group/Policy # _____

Primary Card Holder's Name and Birthdate _____

Person responsible for payment:

Name _____ Relationship _____

Address _____ Home Phone _____

1. Do you use cigarettes/tobacco? ❑ Y ❑ N Alcohol? ❑ Y ❑ N Other Substances? ❑ Y ❑ N
2. Do you have a family history of glaucoma? ❑ Y ❑ N If yes, what relation? _____
3. Do you have a family history of diabetes? ❑ Y ❑ N If yes, what relation? _____
4. Do you wear glasses? ❑ Y ❑ N Contact Lenses? ❑ Y ❑ N How long? _____
5. List any past or present diseases, infections, injuries or surgeries of the eye. ❑ None _____

   _____
6. Do you have or have you had any of the following:

High Blood Pressure	❑ Y	❑ N	How long? _____
Heart disease	❑ Y	❑ N	How long? _____
Asthma or lung disease	❑ Y	❑ N	How long? _____
Seizures or fainting	❑ Y	❑ N	How long? _____
Diabetes	❑ Y	❑ N	How long? _____
Genetic disease	❑ Y	❑ N	How long? _____

7. Please list allergies or reactions or medications. ❑ None _____

   _____
8. Please list all medications taking now. ❑ None _____

   _____

If new patient, how did you hear about our office? _____

_____