



**PATIENT PROFILE**

Please Print/Thank you

Date \_\_\_\_\_

**Patient Name** \_\_\_\_\_ **Gender M / F**

**(First name, middle initial, last name)**      **Marital Status** \_\_\_\_\_

**Caucasian, African American, Hispanic, Other** \_\_\_\_\_

(please circle one, optional)

**Address** \_\_\_\_\_ **Date of birth** \_\_\_\_\_

**City** \_\_\_\_\_, **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Home Phone ( )** \_\_\_\_\_ **Work Phone ( )** \_\_\_\_\_

**Email Address** \_\_\_\_\_

**Social Security#** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Parent or Spouse Name** \_\_\_\_\_ **Phone ( )** \_\_\_\_\_

**Nursing Home Patient Y / N**    **Facility** \_\_\_\_\_

**Guarantor** (Financially responsible Person if other than patient) \_\_\_\_\_

**Social Security#** \_\_\_\_\_

**Address** \_\_\_\_\_ **Date of birth** \_\_\_\_\_

**City** \_\_\_\_\_, **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Employer** \_\_\_\_\_ **Work Phone ( )** \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_ **I.D. #** \_\_\_\_\_

**Policy Holder** \_\_\_\_\_ **Date of birth** \_\_\_\_\_

**Secondary Ins.** \_\_\_\_\_ **I.D. #** \_\_\_\_\_

**Policy Holder** \_\_\_\_\_ **Date of birth** \_\_\_\_\_

(Please Provide Insurance Cards for us to Copy and scan)

• ***EMERGENCY CONTACT OUTSIDE THE HOME***

**Name** \_\_\_\_\_ **Phone ( )** \_\_\_\_\_

**Relationship to patient** \_\_\_\_\_

**Primary Care Doctor**

\_\_\_\_\_

First name last name

**Optometrist**

\_\_\_\_\_

First name last name

**Whom do we thank for recommending our practice?**

\_\_\_\_\_

## HEALTH HISTORY

Yes No <input type="checkbox"/> <input type="checkbox"/> Asthma _____ <input type="checkbox"/> <input type="checkbox"/> Kidney Disease _____ <input type="checkbox"/> <input type="checkbox"/> Tuberculosis _____ <input type="checkbox"/> <input type="checkbox"/> Diabetes IDDM/Type II ___ # of yrs _____ <input type="checkbox"/> <input type="checkbox"/> Insulin _____ <input type="checkbox"/> <input type="checkbox"/> Migraines _____ <input type="checkbox"/> <input type="checkbox"/> Psychiatric Disorder _____ <input type="checkbox"/> <input type="checkbox"/> Any nervous disorder _____ <input type="checkbox"/> <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> <input type="checkbox"/> Ulcer _____ <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Anemia _____ <input type="checkbox"/> <input type="checkbox"/> Do you Smoke? _____ <input type="checkbox"/> <input type="checkbox"/> Do you Drink? _____ <input type="checkbox"/> <input type="checkbox"/> Within the last twelve (12) months have you taken any illegal substances? _____	Yes No <input type="checkbox"/> <input type="checkbox"/> Head or Spinal Injuries _____ <input type="checkbox"/> <input type="checkbox"/> Seizures, Convulsions, or Fainting _____ <input type="checkbox"/> <input type="checkbox"/> Extensive Confinement by illness or injury _____ <input type="checkbox"/> <input type="checkbox"/> Are you allergic to latex? _____ <input type="checkbox"/> <input type="checkbox"/> Suffering from any other disease _____ <input type="checkbox"/> <input type="checkbox"/> Carotid Artery Disease _____ <input type="checkbox"/> <input type="checkbox"/> Permanent Defect from Illness, Disease or injury _____ <input type="checkbox"/> <input type="checkbox"/> (Women) Are you Pregnant? _____ <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure _____ # of yrs _____ <input type="checkbox"/> <input type="checkbox"/> Stroke _____ <input type="checkbox"/> <input type="checkbox"/> HIV _____ <input type="checkbox"/> <input type="checkbox"/> Are your immunizations current? _____ <input type="checkbox"/> <input type="checkbox"/> Cancer _____
---	--

Please List All Medications You Are Currently <b>TAKING</b> :	Please <b>List</b> all Medications You Are Allergic to <b>AND REACTIONS</b>

**YOUR OCULAR HISTORY** (Have you been diagnosed with any of the following in the past year?)

Cataract Surgery (Date of Surgery)    Right    Left _____ Retina Surgery (Date of Surgery)    Right    Left _____ Explanation of Eye Injury                      Right    Left _____	Yes No <input type="checkbox"/> <input type="checkbox"/> Cornea Disease _____ <input type="checkbox"/> <input type="checkbox"/> Glaucoma _____ <input type="checkbox"/> <input type="checkbox"/> Injury _____ <input type="checkbox"/> <input type="checkbox"/> Cataracts _____ <input type="checkbox"/> <input type="checkbox"/> Retina Disease _____ <input type="checkbox"/> <input type="checkbox"/> Crossed Eyes _____ <input type="checkbox"/> <input type="checkbox"/> Iris _____ <input type="checkbox"/> <input type="checkbox"/> Other Eye Disorders _____
---	--

YOUR SURGERY HISTORY (Please include Date & Type)

**FAMILY HISTORY** (Has anyone in your family (blood relative) had any of the following?)

**(RELATION TO PATIENT)**    F - Father       M - Mother       S - Sister       B - Brother  
    GF - Grandfather       GM - Grandmother       U - Uncle       A - Aunt

Yes No <input type="checkbox"/> <input type="checkbox"/> Glaucoma _____ <input type="checkbox"/> <input type="checkbox"/> Cataracts _____ <input type="checkbox"/> <input type="checkbox"/> Cornea Disease _____ <input type="checkbox"/> <input type="checkbox"/> Macular Degeneration _____ <input type="checkbox"/> <input type="checkbox"/> Retinitis Pigmentosa _____ <input type="checkbox"/> <input type="checkbox"/> Other Eye Problems _____	Yes No <input type="checkbox"/> <input type="checkbox"/> Diabetes IDDM/Type II _____ <input type="checkbox"/> <input type="checkbox"/> Heart _____ <input type="checkbox"/> <input type="checkbox"/> Diabetic Retinopathy _____ <input type="checkbox"/> <input type="checkbox"/> Retinal Detachment _____ <input type="checkbox"/> <input type="checkbox"/> Stroke _____ <input type="checkbox"/> <input type="checkbox"/> Cancer _____
---	--

Tech Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_\_