

Name:
Account#:

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Suffix: _____

Home Phone: _(_____) _____ Work: _(_____) _____ Cell:_(_____) _____

Preferred Contact#: Home Work Cell Marital Status: Sing Mar Div Wid Sep

SSN: _____ DOB: _____ Sex: M F

Preferred Language: English Spanish Other _____

Street Address/City/State/Zip: _____

Billing Address: _____

Email Address: _____ Employer/Occupation: _____

Full Time Resident? Y N If No, Other Address: _____

Primary Care Physician: _____ Address: _____

Who Can We Thank For Referring You To Our Practice:

- Family/Friend
- Social Media
- Website
- Employer
- Insurance
- Doctor: _____
- Other: _____

GUARANTOR OR RESPONSIBLE PARTY: Self (Patient) Other (If Patient Is Minor)

If Other, Last Name: _____ First Name: _____ MI: _____ Suffix: _____

Home Phone: _(_____) _____ Work: _(_____) _____ Cell:_(_____) _____

DOB: _____ Relationship To Patient: _____

EMERGENCY CONTACT (Other than telephone number listed above)

Name: _____ Relationship To Patient: _____

Home Phone: _(_____) _____ Work: _(_____) _____ Cell:_(_____) _____

PRIMARY MEDICAL INSURANCE

Company: _____ ID#: _____ Group#: _____

Policyholder Name: _____ DOB: _____ Relationship To Patient: _____

SECONDARY MEDICAL INSURANCE

Company: _____ ID#: _____ Group#: _____

Policyholder Name: _____ DOB: _____ Relationship To Patient: _____

VISION INSURANCE

ID#: _____ Group#: _____ Policyholder Name: _____

DOB: _____ Relationship To Patient: _____

PATIENT MEDICAL HISTORY

NAME: _____

DATE: _____

Please check YES or NO if you have or ever had any of the following:

- | | | | | | |
|----------------------------|----------------------------|---|----------------------------|----------------------------|---|
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Cancer - Type_____ | <input type="checkbox"/> Y | <input type="checkbox"/> N | High Cholesterol |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Taken Flomax / Hytrin / Cardura | <input type="checkbox"/> Y | <input type="checkbox"/> N | Thyroid Disease |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | High Blood Pressure | <input type="checkbox"/> Y | <input type="checkbox"/> N | Diabetes – <input type="checkbox"/> Oral <input type="checkbox"/> Diet <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Stroke / CVA | <input type="checkbox"/> Y | <input type="checkbox"/> N | GERD |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Disease / Murmur | <input type="checkbox"/> Y | <input type="checkbox"/> N | Kidney Disease |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Attack | <input type="checkbox"/> Y | <input type="checkbox"/> N | Kidney Stones |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Congestive Heart Failure | <input type="checkbox"/> Y | <input type="checkbox"/> N | Liver Disease |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Irregular Heartbeat / Palpitations | <input type="checkbox"/> Y | <input type="checkbox"/> N | Hepatitis – <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Asthma | <input type="checkbox"/> Y | <input type="checkbox"/> N | Auto-Immune Disease – Type_____ |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | COPD | <input type="checkbox"/> Y | <input type="checkbox"/> N | Infectious Diseases_____ |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Migraines | <input type="checkbox"/> Y | <input type="checkbox"/> N | Dementia / Memory Loss |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Arthritis | <input type="checkbox"/> Y | <input type="checkbox"/> N | MRSA |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Sleep Apnea - Use a CPAP? <input type="checkbox"/> Y <input type="checkbox"/> N | | | |

Have you received a pneumonia vaccine? Y N

Have you ever smoked? Y N - Do you still smoke? Y N

Do you drink alcohol? Y N - Daily Occasionally Rarely

SURGERIES

Please check the box if you have had any of the surgeries listed below:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> No Surgical Procedures | <input type="checkbox"/> Cataract Surgery |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Prostate | <input type="checkbox"/> Thyroidectomy | <input type="checkbox"/> LASIK / RK |
| <input type="checkbox"/> Heart Stints | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Cornea Transplant |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Glaucoma Procedure |
| | | | <input type="checkbox"/> Eyelid Procedure |

OTHER EYE DIAGNOSIS

Have you been diagnosed with any of the following eye diseases/disorders:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Corneal Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Amblyopia / Lazy Eye | <input type="checkbox"/> Other _____ |

ALLERGIES

Yes – Please list below No Known Allergies Latex Allergy? Yes No

MEDICATIONS

Please list any medications you take, prescription or over the counter; You may provide a list if available:

FAMILY HISTORY

Do you have any FAMILY history of:

(Mother, Father, Siblings, Grandparents)

- | | | | |
|----------------------|----------------------------|----------------------------|------------|
| Diabetes | <input type="checkbox"/> Y | <input type="checkbox"/> N | Who: _____ |
| Glaucoma | <input type="checkbox"/> Y | <input type="checkbox"/> N | Who: _____ |
| Macular Degeneration | <input type="checkbox"/> Y | <input type="checkbox"/> N | Who: _____ |
| Blindness | <input type="checkbox"/> Y | <input type="checkbox"/> N | Who: _____ |
| Adopted/Unknown | <input type="checkbox"/> Y | <input type="checkbox"/> N | |

NOTE: Printed copies of this document are uncontrolled. In the case of a conflict between printed and electronic versions of this document, the controlled version published online prevails.

REVIEW OF SYSTEMS

NAME: _____ DATE: _____

Please check all that apply to your **current** and **past** health.
Boxes that are not checked will be considered a negative response.

General / Constitutional

- Overall Healthy
- Weight Loss / Gain
- Fatigue
- Fever and Chills
- Weakness

Integumentary (Skin)

- Skin Cancer
- Rash
- Bruising
- Suspicious growths
- Itching

Ears/Nose/Mouth/Throat

- Dry Mouth
- Sinus Pain / Infections
- Ringing in ears
- Vertigo
- Wears hearing aids

Respiratory

- COPD
- Asthma
- Emphysema
- Oxygen use
- Shortness of Breath

Cardiovascular

- Chest Pain
- Hypertension
- Heart attack
- Heart Surgery
- Palpitations

Gastrointestinal

- Heartburn / Acid reflux
- Diverticulitis
- Nausea
- Hernia
- Ulcers

Musculoskeletal

- Arthritis
- Back pain
- Swelling of joints
- Stiffness
- Muscle pain / joint pain

Neurological

- Memory Loss
- Headaches
- Parkinson's disease
- Seizures
- Tremors

Endocrine

- Diabetes
- Hyperthyroidism
- Hypothyroidism
- Frequent Urination
- Excessive thirst

Psychiatric

- Anxiety
- Depression
- Stress

Allergies / Immunological

- Allergic reaction to medications
- Allergic reaction to foods
- Seasonal / Environmental allergies
- Autoimmune disease

Other conditions or medical problems not listed?:

X _____
Patient Signature

_____ Date

X _____
Parent or Guardian Signature

_____ Date

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Name: _____ Date: _____ Acct#: _____

VISUAL ASSESSMENT FORM AND LIFESTYLE QUESTIONNAIRE

Occupation: _____

Hobbies: _____

Circle the degree of difficulty you have doing the following activities because of your vision.

Functional Vision Assessment

Circle One

Would you like to be less dependent on glasses??	Distance	Near	Both	
Difficulty seeing street signs or driving (curbs, highway exits, traffic lights, halos/glare in lights)	No	Mild	Moderate	Severe
Difficulty seeing TV or movies (faces, numbers, printing)	No	Mild	Moderate	Severe
Difficulty reading small print with glasses (books, newspaper, pill bottles, instructions, cell phone)	No	Mild	Moderate	Severe
Difficulty performing detailed work (sewing, threading a needle, baiting a hook)	No	Mild	Moderate	Severe
Difficulty with personal correspondences (writing checks, reading bills, filling out forms)	No	Mild	Moderate	Severe
Difficulty with leisure activities (playing cards, bingo, bowling, golfing)	No	Mild	Moderate	Severe
Difficulty functioning around the house (cooking, general household upkeep, stairs, telephone)	No	Mild	Moderate	Severe
Difficulty recognizing faces of people (church, grocery store, clubs, other daily activities)	No	Mild	Moderate	Severe

Please circle the activities you would prefer to do with less dependence on glasses:

Reading Seeing pill bottles Looking at a menu Looking at your watch Using a cell phone
Card or table games Sewing Applying makeup Using a computer
View dashboard of car Seeing price tags/shelves Shopping Bingo Driving
Playing sports, like golf Watching TV Watching live sports Going to movies Swimming

X _____
Patient Signature

Date

X _____
Parent or Guardian Signature

Date

ATTENTION: If you speak English or American Sign Language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Please speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Por favor hable con su proveedor.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Bitte sprechen Sie mit Ihrem Provider.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。请与您的提供商联系。

注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請與您的提供者聯絡。

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Hãy nói chuyện với nhà cung cấp của bạn.

ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Veuillez en parler à votre fournisseur.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Пожалуйста, поговорите со своим провайдером.

تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية المجانية متوفرة متاح لك. المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات والتنسيقات التي يمكن الوصول إليها متاحة أيضًا مجانًا. يرجى التحدث إلى مزود الخدمة الخاص بك.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 귀하의 서비스 제공자에게 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Makipag-usap sa iyong provider.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Si prega di parlare con il proprio fornitore.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòm aksesib yo disponib gratis tou. Tanpri pale ak founisè w la.

ማሳሰቢያ:- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጾች ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። እባክዎን አቅራቢዎን ያነጋግሩ።

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि दनःशुल्क भादषक सहायता सेवाहरू उपलब्ध छन्। पढ्नु चयोग्य ढाँचाहरूमा जानकारी प्रिन्टिन्ट उपयुक्त सहायता र सेवाहरू पदन दनिःशुल्क उपलब्ध छन्।

कृपया आपनो प्रदायकसँग कुरा गर्नुहोस्।

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Tafadhali zungumza na mtoa huduma wako.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。プロバイダーにご相談ください。

توجه: اگر فارسی صحبت می کنید، خدمات کمک زبان رایگان است در دسترس شماست. کمک‌ها و خدمات کمکی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس نیز به صورت رایگان در دسترس هستند. لطفاً با ارائه‌دهنده خود صحبت کنید.

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Thov nrog koj tus kws kho mob tham.

ATENÇÃO: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Por favor, fale com seu provedor.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। कृपया अपने प्रदाता से बात करें।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Proszę porozmawiać ze swoim dostawcą.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। আপনার প্রদানকারীর সাথে কথা বলুন।

قابل رسائی فارمیٹس میں معلومات فراہم اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ توجہ دیں: براہ کرم اپنے فراہم کنندہ سے بات کریں۔ کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔