PLEASE COMPLETE BOTH SIDES OF THIS FORM

Date _____

PERSONAL INFORMATION E-mail Address:

Patient Name	□ Male □ Female	Social Security Number	Date of Birth	Age
Street Address	City State / Zip		Home Phone or Cell Phone	
Occupation	Employer or Name of School		□ Full Time Student □ Part Time Student	
Work Address	City State / Zip		Work Phone	
Preferred Pharmacy (with Location)	Primary Care Physician		Referring Physician (if applicable)	
Other physicians involved in your care (please list):				
Marital Status (circle one) Single Married Widowed Divorced	Spouse / Guardian / Sig. Other		□ Male □ Female	Date of Birth
Address (if different from patient's)	City State / Zip		Home Phone or Cell Phone	
Occupation	Employer or Name of School		Work Phone	
United States Government Required Questions (Please check a box for each section)	Race: □ Black □ Asian □ Hispanic □ White □ Prefer not to answer Ethnicity: □ Latino □ Non Latino □ Prefer not to answer Primary Language: □ English □ Other □ Sign Language			
Emergency Contact	Relationship to Patient		Home Phone or Cell Phone	
Address (if different from patient's)	City State / Zip		Work Phone	
How did you hear of us? (Please check all applicable)	□ Referral from another Physician □ Referral from friend / current patient □ Online or Paper Advertisement □ Event / Health Fair □ Walk-in			

Insurance

Primary	Member ID	Insured Name	Relation to patient:	Date of Birth
Insured Address (if different from patients)	City State / Zip		Insured Member's Phone Number	
Secondary	Member ID	Insured Name	Relation to patient:	Date of Birth
Insured Address (if different from patients)	City State / Zip		Insured Member's Phone Number	

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Worker's Comp / No Fault Date of Injury:

Employer (at time of injury)	Employer Address	Employer Phone
Employer's Insurance Carrier	Insurance Address	Insurance Phone
Workers Comp Case Number		Carrier Case Number

PAST MEDICAL HISTORY

Alcohol Use (circle one)
Never Rarely Occasionally Daily

Caffeine use (circle one)
Never Rarely Occasionally Daily
Cups per day _____

Smoking: Have you smoked at least 100 cigarettes in your life?
Yes, current, every day_____ Yes, current, some days_____
Packs per day_____ Number of years smoked_____
Yes, former smoker, quit_____ When did you quit?_____
No, Never Smoked_____ Do you use smokeless tobacco? _____
Are you exposed to second hand smoke? _____

Allergies (to medications, food, substances, etc)

Past Surgical History (list dates and operations)

Medications / Vitamins / Supplements (list any medications, vitamins and supplements that you are on)

Have you ever taken, even if only once: Flomax, Hytrin, Cardura, or Uroxatral? Y N

Symptoms – Check all that you have or have had

_____ Impaired Hearing
_____ Sinus Problems
_____ Loss of Sleep
_____ Anxiety
_____ Headaches
_____ Fainting
_____ Numbness
_____ Head Injury
_____ Stomach Problems
_____ Back Pains
_____ Excessive Hunger
_____ Hives
_____ Venereal Disease
_____ AIDS
_____ Ear Problems
_____ Nosebleeds
_____ Loss of Weight
_____ Depression
_____ Migraines
_____ Dizziness
_____ Poor Circulation
_____ Unconsciousness
_____ Intestinal Pains
_____ Urinary Problems
_____ Excessive Thirst
_____ Rash

Family History – Please check the following relevant sections below:

	You	Mother	Father	Sibling
Asthma, Hay Fever:	___	___	___	___
Blindness:	___	___	___	___
Cancer:	___	___	___	___
Cataract:	___	___	___	___
Chem/Alcohol Depend:	___	___	___	___
Diabetes (include type):	___	___	___	___
Glaucoma:	___	___	___	___
Heart Disease/Stroke:	___	___	___	___
High Blood Pressure:	___	___	___	___
Kidney Disease:	___	___	___	___
Tuberculosis:	___	___	___	___

Eye Conditions – Check conditions you have or have had in the past

_____ Blurred Vision
_____ Cataracts
_____ Corneal Transplant
_____ Crossed Eyes
_____ Double Vision
_____ Droopy Eyelids
_____ Excessive Tearing
_____ Eye Infection
_____ Eye Injury
_____ Eyelid Lesion
_____ Eye Surgery (specify)
_____
_____ Floaters
_____ Glaucoma
_____ Loss of Vision
_____ Seeing Flashes
_____ Seeing Halos
_____ Retinal Disease
____ Sensitivity to light
____ Wear Contacts
Type of lenses _____
Hours per day _____
____ Wear Glasses
Type of lenses _____