PATIENT INFORMATION

Date________________

Name____
Last First Middle

Address ____

City________________________ State_______ Zip ____________

Date of Birth_____/_____/_____ Age_____ Marital Status ________________

☐ Male ☐ Female ☐ Other Preferred pronouns_______ Preferred name to be used __________

Home Phone (____)________ Cell Phone (____)________ Work Phone (____) ________

E-mail__________________________ Social Security #______________

Best Method of Contact (Check one) ☐ Home ☐ Cell ☐ Work ☐ Email

Employer____________________ Occupation ____________________

List your hobbies or activities that require special visual needs ____________________

HOW WERE YOU REFERRED TO THIS OFFICE?

(Check one) ☐ My Eye Doctor ☐ My PCP ☐ Insurance ☐ Internet

Who is your Eye Doctor?_______________________ City ______________

IN CASE OF EMERGENCY, CONTACT

Name____________________________ Phone (____) ____________

MEDICAL/VISION INSURANCE INFORMATION (Attach copy of cards)

Insurance Company__________________ Group/Policy#__________________

Policy Holder____________________ Member/ID#____________________

Date of Birth_____/_____/_____ Sex_____ Relationship to Policy Holder ______________

I understand that dilating drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until I am certain the effect of the medicine has worn off. The effect of the drops may last an hour or longer.

Signed______________________________ Date________________

MEDICAL HISTORY QUESTIONNAIRE

NAME:______________________________ **DATE:** ____

Preferred pharmacy: ____

Pharmacy address: ____

List any medications you currently take (prescription and over-the-counter):

____

____

Do you have allergies to any medications? ☐ Yes ☐ No If yes, please list the medications:

____

____

EYE HISTORY

Any eye disorders	☐ Yes	☐ No	Retinal tear or detachment	☐ Yes	☐ No
Glaucoma (High eye pressure)	☐ Yes	☐ No	Cataract	☐ Yes	☐ No
Dry eye syndrome	☐ Yes	☐ No	Recurrent corneal erosion	☐ Yes	☐ No
Amblyopia (“lazy eye”)	☐ Yes	☐ No	Keratoconus	☐ Yes	☐ No
Any eye injury	☐ Yes	☐ No	Any eye dystrophy or degeneration	☐ Yes	☐ No
Eye surgery	☐ Yes	☐ No	Any herpes infection in the eye	☐ Yes	☐ No
ALK/RK/LASIK/PRK Surgery	☐ Yes	☐ No	Other	☐ Yes	☐ No
Any infection in the eye	☐ Yes	☐ No	________________________		

If you answered yes to any of the above please explain: ____

____

____

SOCIAL HISTORY

Do you currently wear glasses? ☐ Yes ☐ No

If yes, how old is the current prescription?______________ When was your last eye exam? __________________

Do you drink alcohol? ☐ Yes ☐ No

If yes: ☐ Occasional ☐ 1 per day ☐ 2-3 per day ☐ 4+ per day

Do you smoke? ☐ Yes ☐ No

If yes: ☐ Occasional ☐ 1/2 pack per day ☐ 1 pack per day ☐ 1+ pack per day

Have you ever had a blood transfusion? ☐ Yes ☐ No

RETINA CONSULTANTS OF ORANGE COUNTY

MEDICAL HISTORY QUESTIONNAIRE (PAGE 2)

OVERALL HEALTH	YES	NO	DETAILS
General / Constitutional (Fever, Weight Loss, etc.)			
Ears, Nose, Throat (Stuffy Nose, Earache, Cough, Dry Mouth, etc.)			
Cardiovascular (High Blood Pressure, Racing Pulse, etc.)			
Respiratory (Congestion, Wheezing, etc.)			
Gastrointestinal (Stomach Upset, Diarrhea, Constipation, etc.)			
Genital, Kidney Bladder (Painful Urination, Frequent Urination, Impotence, etc.)			
Muscles, Bones, Joints (Joint Pain, Stiffness, Swelling, Cramps, etc.)			
Skin (Pimples, Warts, Growths, Rashes, etc.)			
Neurological (Numbness, Headache, etc.)			
Psychiatric (Anxiety, Depression, Insomnia, etc.)			
Endocrine (Diabetes, Hypothyroid, etc.)			
Blood / Lymph (Cholesterolemia, Anemia, etc.)			
Allergic / Immunologic (Sneezing, Swelling, Redness, Itching, Hives, etc.)			

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP TO PATIENT M = Mother F = Father S = Sibling G = Grandparent
Arthritis			
Blindness			
Cancer			
Diabetes			
Glaucoma			
Heart Disease or High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Other			