# Patient Information

Last Name _____ First _____ Middle_____

Nickname _____ Gender: Male Female DOB _____/_____/_____

Address _____

City _____ State _____ Zip _____

Home Phone _____-_____-_____ Work _____-_____-_____ Ext _____

Cell _____-_____-_____ Which number would you prefer we call to contact you? Home Work Cell

Email _____

Language _____ Race _____ Hispanic or Latino? Yes No

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If patient is a minor, Guardian:

Last Name _____ First _____ M _____

Relationship_____ Contact number _____-_____-_____

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Emergency Contact Name _____ Relation _____

Phone _____-_____-_____

***Please provide vision and / or medical insurance coverage. Please bring insurance and ID cards to front desk for us to make copies.***

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**Primary Vision Insurance**_____

ID # _____ Group #_____

Insured's Name _____ Insured's Birth Date _____/_____/_____

Relationship to Insured: Self Spouse Child Other

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**Primary Medical Insurance** _____

ID # _____ Group #_____

Insured's Name _____ Insured's Birth Date _____/_____/_____

Relationship to Insured: Self Spouse Child Other

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**Secondary Medical Insurance** _____

ID # _____ Group #_____

Insured's Name _____ Insured's Birth Date _____/_____/_____

Relationship to Insured: Self Spouse Child Other

# Medical Questionnaire  Patient Name _____

**Who is your primary physician?**

Name _____ Phone _____-_____-_____

Please list any allergies to medications:  No Known Allergies  Latex Sensitivity:  Yes  No

Please list any prescription medications you are currently taking, including prescription eyedrops:

Please list any supplements or non-prescription medications, including any non-prescription eyedrops:

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Do you smoke?  Yes  No  Former

If you do smoke, how much per day? _____  For how many years? _____

Cigarettes  Cigars  Pipe  Smokeless Tobacco

Do you drink alcohol?  No  Yes  How much per day? _____

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Do you wear eyeglasses?  No  Yes  Only for distance  Only for reading  Full-time

Do you currently wear contact lenses?  No  Yes  Are you interested in contact lenses?  No  Yes

Please circle any current conditions that apply:

**Constitution:**
- Developmental Disabilities
- Cancer
- Fatigue Syndrome
- Other

**Ear/Nose/Throat:**
- Hearing Loss
- Sinusitis
- Dry Mouth
- Laryngitis
- Other

**Neurological:**
- Multiple Sclerosis
- Epilepsy
- Cerebral Palsy
- Tumor
- Stroke
- Migraine
- Other

**Psychological:**
- Depression
- Attention Deficit Disorder
- Anxiety
- Bipolar
- Other

**Cardiology:**
- Hypertension (high blood pressure)
- Heart Disease/Heart Attack
- Vascular Disease
- Congestive Heart Failure
- Other

**Respiratory:**
- Asthma
- Bronchitis
- Emphysema
- Chronic Obstruction(COPD)
- Sleep Apnea
- Other

**Gastro-intestinal:**
- Crohn's
- Colitis
- Ulcer/Acid Reflux
- Celiac Disease
- Other

**Genital Urinary:**
- Kidney Disease
- Prostate Disease/Cancer
- STD
- Pregnant (currently)
- Nursing
- Herpes
- Chlamydia
- Other

**Musculo-Skeletal**:
- Osteoarthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Osteoporosis
- Arthritis
- Gout
- Other

**Integumentary:**
- Eczema
- Rosacea
- Psoriasis
- Herpes Simplex/Cold Sores
- Herpes Zoster/Shingles
- Other

**Endocrinology:**
- Type 2 Diabetes
- Type 1 Diabetes
- Thyroid Dysfunction
- Hormonal Dysfunction
- Other

**Hematology/Lymphatic:**
- Anemia
- Large volume blood loss
- Ulcer
- Hypercholesteremia
- Other

**Allergy/Immune:**
- Rheumatoid Arthritis
- Lupus
- Sjogrens Syndrome
- Other