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):			Optometrist (if applicable)	
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 ______AIDS
______ Sinus Problems ______Ear Problems
______ Loss of Sleep ______Nosebleeds
______ Anxiety ______Loss of Weight
______ Headaches ______Depression
______ Fainting ______Migraines
______ Numbness ______Dizziness
______ Head Injury ______Poor Circulation
______ Stomach Problems ______Unconsciousness
______ Back Pains ______Intestinal Pains
______ Excessive Hunger ______Urinary Problems
______ Hives ______Excessive Thirst
______ Venereal Disease ______Rash

Family History – Check if **YOU** or **YOUR** blood relatives have had any of the following

_____Arthritis, Gout ____________________________
_____Asthma, Hay Fever ______________________
_____Blindness ________________________________
_____Cancer __________________________________
_____Cataract _________________________________
_____Chemical/Alcohol Dependency ___________
_____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 _____ Excessive Tearing _____ Floaters ____ Sensitivity to light
_____ Cataracts _____ Eye Infection _____ Glaucoma ____ Wear Contacts
_____ Corneal Transplant _____ Eye Injury _____ Loss of Vision Type of lenses _______
_____ Crossed Eyes _____ Eyelid Lesion _____ Seeing Flashes Hours per day _______
_____ Double Vision _____ Eye Surgery (specify) _____ Seeing Halos ____ Wear Glasses
_____ Droopy Eyelids ____________________________ _____ Retinal Disease Type of lenses ______