SOMERS EYE CENTER PATIENT HEALTH HISTORY

NAME: _____ DATE: _____

REASON FOR YOUR VISIT: _____

DURATION OF SYMPTOMS/PROBLEMS _____ REFERRED BY: _____

ALLERGIES TO MEDICATIONS: _____

CURRENT MEDICATIONS: _____

_____

PNEUMOCOCCAL VACCINATION Y N INFLUENZA IMMUNIZATION Y N COVID VACCINATION Y N

PAST EYE HISTORY: (CIRCLE IF APPLICABLE)

GLASSES: CURRENT/PAST/NEVER CONTACT LENSES: CURRENT/PAST/NEVER
CATARACTS: CURRENT/PAST/NEVER CATARACT SURGERY: WHAT YEAR RIGHT EYE ____ LEFT EYE____
RETINAL DISEASE: CURRENT/PAST/NEVER RETINAL DETACHMENT: EYE AND WHEN _____
LASER SURGERY: WHICH EYE AND WHEN _____ REFRACTIVE SURGERY: _____
CORNEAL TRANSPLANT: WHICH EYE AND WHEN _____

PAST MEDICAL HISTORY: (CIRCLE IF APPLICABLE)

ARTHRITIS ASTHMA/LUNG DISEASE BLINDNESS BLOOD DISORDER CANCER DIABETES
DIGESTIVE DISORDER GLAUCOMA HEARING PROBLEM HEART DISEASE HIGH BLOOD PRESSURE
HIGH CHOLESTEROL LIVER DISEASE MACULAR DEGENERATION MIGRAINE HEADACHES
PSYCHIATRIC DISORDER SEIZURES SEASONAL ALLERGIES SKIN DISEASE STROKE
LIST ANY SURGERIES OR HOSPITALIZATIONS WITH DATES:

_____

_____

FAMILY HISTORY: PLEASE INDICATE WHICH FAMILY MEMBER HAD THE MEDICAL CONDITIONS:
(M) MOTHER, (F) FATHER, (GM) GRANDMOTHER, (GF) GRANDFATHER, (S) SISTER, (B) BROTHER

ARTHRITIS _____ ALLERGIES _____ ASTHMA _____ BLINDNESS _____
CANCER _____ DIABETES _____ GLAUCOMA _____ HEART DISEASE _____
HIGH BLOOD PRESSURE _____ MACULAR DEGENERATION _____ STROKE _____

PATIENT INFORMATION FORM

LAST NAME: _____ FIRST NAME: _____ MIDDLE INT: __

SEX: _____ PREFERRED LANGUAGE: _____ RACE & ETHNICITY: _____

MAILING ADDRES: _____

CITY, STATE, ZIP CODE: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

HOME #: _____ WORK #: _____ CELL#: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

INSURANCE CARRIER: _____

POLICY HOLDER NAME: _____ RELATIONSHIP: _____

POLICY HOLDER DATE OF BIRTH: _____ POLICY HOLDER SSN: _____

INSURANCE ID: _____ GROUP#: _____

RESPONISBLE PARTY NAME: _____

ADDRESS: _____

PHONE: _____

PRIMARY CARE PHYSICIAN: _____

PHONE #: _____ Fax #: _____

PHARMACY OF CHOICE: _____

LOCATION: _____

PHONE #: _____ FAX #: _____

PLEASE CIRCLE:

SINGLE MARRIED DIVORCED WIDOWED

STUDENT RETIRED DISABLED

SOCIAL HISTORY:

SMOKE: Y N PACKS PER DAY____ ALCOHOL INTAKE: NONE/OCCASION/DAILY AMOUNT_____

PATIENT SIGNATURE: _____

DATE: _____