PATIENT INFORMATION

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INT:**_____

MAILING ADDRESS:_____

CITY, STATE, ZIP CODE:_____

GENDER: _____ **MARITAL STATUS:** SINGLE /MARRIED /WIDOWED /DIVORCED

DATE OF BIRTH: _____ **SOCIAL SECURITY#:**_____

PREFERRED LANGUAGE: _____ **RACE/ETHNICITY:**_____

EMPLOYER:_____

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

EMAIL ADDRESS:_____

ALTERNATIVE CONTACT PERSON:

NAME:_____ **RELATIONSHIP:**_____

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

EMAIL ADDRESS:_____

PRIMARY INSURANCE CARRIER: _____

INSURANCE ID: _____ **GROUP #:**_____

POLICY HOLDER NAME (if not yourself): _____

RELATIONSHIP:_____**DATE OF BIRTH:**_____**SOCIAL SECURITY #:**_____

RESPONSIBLE PARTY NAME (if not yourself):

NAME:_____

PHONE #: _____

ADDRESS:_____

PRIMARY CARE PHYSICIAN NAME: _____

PRACTICE NAME:_____

if known: PHONE #: _____**FAX #:** _____

PHARMACY OF CHOICE: _____**LOCATION:**_____

if known: PHONE #:_____**FAX#:**_____

PATIENT SIGNATURE: _____ **DATE:** _____

PATIENT HEALTH HISTORY

VACCINATIONS /IMMUNIZATIONS: (PLEASE CIRCLE ALL THAT APPLY)

1. INFLUENZA IMMUNIZATION (FLU SHOT) within the last 1 year: YES / NO / UNSURE

2. PNEUMOCOCCAL VACCINATION (PNEUMONIA SHOT): YES / NO / UNSURE

3. COVID VACCINATION: YES / NO / UNSURE

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

ALLERGIES	DIGESTIVE DISORDER	KIDNEY DISEASE	STROKE
ARTHRITIS	GLAUCOMA	LIVER DISEASE	SKIN DISEASE
ASTHMA/LUNG DISEASE	HIGH BLOOD PRESSURE	MIGRAINE/ HEADACHES	SEIZURES
BLINDNESS	HARD OF HEARING	MACULAR DEGENERATION	
BLOOD DISORDER	HIGH CHOLESTEROL	PSYCHIATRIC DISORDER	
CANCER	HEART DISEASE	DIABETES	
INFECTIOUS DISEASE	**NONE (Circle if you do not have any medical problems)**		

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE: _____

_____

SURGERIES/ HOSPITALIZATIONS: Please list with DATES (if known), or circle all that apply:

_____ **Please see the list I brought in**

_____ **I don't know all my Surgeries/Hospitalizations**

_____ **I have never had any Surgeries/Hospitalizations**

_____

_____

CURRENT MEDICATIONS: Please list all medications, or circle all that apply:

_____ **Please see the list I brought in**

_____ **I don't know all my medications**

_____ **I don't take ANY medications**

_____

_____

_____

_____

ALLERGIES TO MEDICATIONS: Please list all allergies, or circle all that apply:

_____ **Please see the list I brought in**

_____ **I don't know all my allergies**

_____ **I don't have ANY allergies**

FAMILY MEDICAL HISTORY:

PLEASE INDICATE BY **CIRCLING WHICH FAMILY MEMBER** HAD THE MEDICAL CONDITION(S):

(M) MOTHER, **(F)** FATHER, **(GM)** GRANDMOTHER, **(GF)** GRANDFATHER,

(SS) SISTER, **(B)** BROTHER, **(A)** AUNT, **(U)** UNCLE, **(S)** SON, **(D)** DAUGHTER

ARTHRITIS: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D----------**ALLERGIES:** M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D

ASTHMA: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D----------**BLINDNESS:** M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D

CANCER: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D----------**DIABETES:** M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D

GLAUCOMA: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D---------**HEART DISEASE:** M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D

HIGH BLOOD PRESSURE: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D----------

MACULAR DEGENERATION: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D----------

STROKE: M/ F/ GM/ GF/ SS/ B/ A/ U/ S/ D----------

NO ONE in my family has any medical problems --------UNKNOWN (I don't know of any / I was adopted)

OTHER MEDICAL CONDITIONS IN FAMILY MEMBERS NOT LISTED ABOVE: _____

_____

SOCIAL HISTORY: (PLEASE CIRCLE WHAT APPLIES IN EACH ROW)

MARITAL STATUS: SINGLE/ MARRIED/ DIVORCED/ WIDOWED

TOBACCO USE:

NEVER

FORMER **(DATE QUIT:** _____**) – great job quitting!**

YES **(DAILY AMOUNT:** _____**)**

TYPE: (cigarettes, pipe, vape, chewing tobacco, etc.)_____

Please note that Dr. Blacklock and Dr. Loughman strongly recommend not smoking, as it causes damage throughout your body, including to your eyes!

ALCOHOL INTAKE:

NONE

OCCASIONAL/SOCIAL

1-2 DRINKS A DAY

3-4 DRINKS A DAY

OTHER DAILY AMOUNT: _____

OCCUPATION: WORKING / STUDENT / RETIRED / DISABLED / UNEMPLOYED

if working, my occupation is_____

FALL RISK: Do you feel you are at risk to fall, or have you fallen in the last year? YES / NO

REASON FOR YOUR VISIT TODAY: _____

_____

DURATION OF SYMPTOMS/ PROBLEMS: _____

Please list anything that you are currently using <u>in your eyes</u> (drops, ointments, saline, etc.):

_____

_____

<u>EYE HISTORY:</u>	**<u>(PLEASE CIRCLE WHAT APPLIES):</u>**		
GLASSES:	CURRENT / PAST / NEVER		
CONTACT LENSES:	CURRENT / PAST / NEVER		
CATARACTS:	RIGHT / LEFT / BOTH / NEVER / UNSURE		
CATARACT SURGERY:	RIGHT / LEFT / BOTH / NEVER / UNSURE		
RETINAL DISEASE:	R / L / B / No	**REFRACTIVE SURGERY:**	R / L / B / No
RETINAL SURGERY:	R / L / B / No	**LASER SURGERY:**	R / L / B / No
RETINAL DETACHMENT:	R / L / B / No	**CORNEAL TRANSPLANT:**	R / L / B / No

How did you hear about us? Did someone specific refer you to us that we could thank with your permission? _____

REFERRED BY: _____

THANK YOU FOR COMPLETING THESE FORMS AND HELPING US PROVIDE YOU WITH THE BEST CARE POSSIBLE!

PATIENT SIGNATURE: _____ **DATE:** _____