PATIENT INFORMATION FORM

Patient Name _____ Date of Birth _____
(First) (Middle Initial) (Last)

Contact Information

Home Phone _____ Work Phone _____

Cell Phone _____ Other (seasonal) _____

At which number would you prefer to receive automated appointment reminders?

❑ Home ❑ Cell ❑ Work ❑ Other (seasonal)

Mailing Address_____ Seasonal Address _____

_____ _____

Personal Information

Sex: ❑ M ❑ F Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Language: ❑ English ❑ Spanish ❑ French ❑ Other _____

The following information is requested by Medicare:

Race: ❑ Decline to Report ❑ American Indian ❑ Black or African American ❑ Caucasian
❑ Other _____

Ethnicity: ❑ Decline to Report ❑ Hispanic ❑ Latino ❑ Not Hispanic or Latino

Emergency Contact(s)

Name of Emergency Contact _____

Phone _____ Relationship to the Patient _____

Employment Information

Employer _____ Occupation _____

Employer Address _____

Doctor Information

Eye Doctor _____ Phone _____

Primary Care Physician _____ Phone _____

Medical History

Please check any major diseases, conditions, or illnesses. Include any conditions for which you are taking medications. Include any relevant details.

- ❑ Diabetes mellitus (see next section for specific questions)
- ❑ Hypertension (high blood pressure)
- ❑ Hyperlipidemia (high cholesterol)
- ❑ Cerebrovascular accident (stroke)
- ❑ Coronary artery disease
- ❑ Myocardial infarction (heart attack)
- ❑ Congestive heart failure
- ❑ Atrial fibrillation
- ❑ Arrhythmia, other (irregular heart beat)
- ❑ Anemia
- ❑ Coagulation defect (clotting disorder)
- ❑ Asthma
- ❑ Chronic obstructive pulmonary disease (COPD, emphysema)
- ❑ Sleep apnea
- ❑ Thyroid disease
- ❑ Chronic renal failure (require dialysis)
- ❑ MRSA, VRE (antibiotic resistant infection)
- ❑ Autoimmune, immune or inflammatory disease
- ❑ Cancer
- ❑ Other major diseases, or explanations for above _____

_____

_____

Surgical History

Include any relevant details such as approximate year of surgeries.

- ❑ Cataract Surgery
- ❑ Other Eye Surgery _____
- ❑ Heart bypass graft (CABG) or heart stent
- ❑ Heart surgery, other
- ❑ Carotid endarterectomy (carotid artery surgery)
- ❑ Amputation
- ❑ Aneurysm repair

❑ OTHER MAJOR SURGERIES OR EXPLANATIONS FOR ABOVE _____

_____

_____

PREFERRED PHARMACY

PHARMACY NAME _____

LOCATION _____

EYE MEDICATIONS

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING FOR THE EYE. INCLUDE DOSES AND WHICH EYE.

_____ _____

_____ _____

OTHER MEDICATIONS

IF NOT PROVIDED IN YOUR OWN DOCUMENT, LEASE LIST ANY OTHER MEDICATIONS YOU ARE CURRENTLY TAKING. INCLUDE DOSES.

_____ _____

_____ _____

_____ _____

_____ _____

MEDICATION ALLERGIES

PLEASE LIST ANY ALLERGIES TO MEDICATIONS. INCLUDE REACTION.

_____ _____

_____ _____