

PATIENT NAME: _____

CHART # _____

APPOINTMENT DATE _____

CURRENT PROBLEMS	No	Yes	CURRENT PROBLEMS	No	Yes	CURRENT PROBLEMS	No	Yes
General			Psychiatric			Have you been diagnosed with...		
Fatigue			Depressed			Diabetes?		
Fever			Irritability			High Blood Pressure?		
Weakness			Nervousness			Glaucoma?		
Weight Gain			Stressed			Have you ever received...		
Weight Loss			Skin			Pneumonia Vaccine?		
Head			Itchy Skin			Year received?		
Hearing Loss			Rash(es)			Cancer (note type, location & year):		
Sinus Problems			Skin Bumps			<input type="checkbox"/> No changes in past 12 months		
Ringing in the Ears			Musculoskeletal			<input type="checkbox"/> None		
Vertigo			Joint Pain			Other Chronic Problems (describe):		
Lungs			Back Pain			<input type="checkbox"/> No changes in past 12 months		
Asthma			Joint Stiffness			<input type="checkbox"/> None		
Cough			Muscle Weakness			Surgery (type and year):		
Shortness of Breath			Blood			<input type="checkbox"/> No changes in past 12 months		
Heart			Bleeding Tendency			<input type="checkbox"/> None		
Chest Pain			Easy Bruising					
Irregular Heartbeat			HIV Positive					
Racing Heart			Hepatitis A					
Digestive			Hepatitis B					
Decreased Appetite			Hepatitis C					
Diarrhea			Do you...					
Nausea			Drink Alcohol?					
Vomiting			Use Illegal Drugs?					
Bladder			Use Tobacco Products?					
Pain with Urination			If yes, which ones?					
Urgency to Urinate			Cigarettes?					
Hormonal			Cigarillos?					
Excessive Thirst			Cigars?					
Excessive Urination			smokeless?					
Neurologic			Chew?					
Dizziness			Usage per day?					
Headache			_____ individual					
Numbness of Extremities			_____ packs					

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Please list any current medications you are taking for your EYES:

None See Attached List

Please list any OTHER medications you are currently taking:

None See Attached List No changes in past 12 months

I'm currently taking Flomax Yes No

I have taken Flomax in the past Yes No

Please list any medication ALLERGIES (include medications & reaction experienced):

None See Attached List No changes in past 12 months

Preferred Pharmacy _____ (name) _____ (location)

Please bring your prescription card

Family History of Eye Disease (list type and family relation):

None See Attached List No changes in past 12 months

Please let us know who we can talk to about your future appointments or your medical information:

Other Doctors: _____

Spouse/Family/Friend: _____ Phone _____

Spouse/Family/Friend: _____ Phone _____

Preferred language if not English: _____

spoken written will bring interpreter

Email Address (for appointment reminders): _____

Do you have an Advance Directive? __ Yes __ No (forms available by request)

Is this patient over 18 years of age? __ Yes __ No (If NO, a legal guardian is required to sign on behalf of the minor, and must be present at each visit or may sign a visit authorization when another adult is to accompany the minor.)

Is this patient an adult making their own decisions? __ Yes __ No (If NO, legal guardianship or Durable Healthcare Power-of-Attorney documents are required. The legal party must sign for the patient, and be present at each visit or sign a visit authorization when another adult is to accompany the patient.)

HIPAA STATEMENT: Our Privacy Notice is posted in the lobby and is available at the front desk. It describes how we may use and disclose your Protected Health Information, as well as your rights regarding such information.

Signature: _____ Patient ___ Guardian ___ Power-of-Attorney

Tech Review Signature

Physician Review Signature