PATIENT NAME:_____ CHART #_____

APPOINTMENT DATE_____

CURRENT PROBLEMS	No	Yes
General		
Fatigue		
Fever		
Weakness		
Weight Gain		
Weight Loss		
Head		
Hearing Loss		
Sinus Problems		
Ringing in the Ears		
Vertigo		
Lungs		
Asthma		
Cough		
Shortness of Breath		
Heart		
Chest Pain		
Irregular Heartbeat		
Racing Heart		
Digestive		
Decreased Appetite		
Diarrhea		
Nausea		
Vomiting		
Bladder		
Pain with Urination		
Urgency to Urinate		
Hormonal		
Excessive Thirst		
Excessive Urination		
Neurologic		
Dizziness		
Headache		
Numbness of Extremities		

CURRENT PROBLEMS	No	Yes
Psychiatric		
Depressed		
Irritability		
Nervousness		
Stressed		
Skin		
Itchy Skin		
Rash(es)		
Skin Bumps		
Musculoskeletal		
Joint Pain		
Back Pain		
Joint Stiffness		
Muscle Weakness		
Blood		
Bleeding Tendency		
Easy Bruising		
HIV Positive		
Hepatitis A		
Hepatitis B		
Hepatitis C		
Do you…		
Drink Alcohol?		
Use Illegal Drugs?		
Use Tobacco Products?		
If yes, which ones?		
Cigarettes?		
Cigarillos?		
Cigars?		
smokeless?		
Chew?		

Usage per day?

_____individual

_____packs

CURRENT PROBLEMS	No	Yes
Have you been diagnosed with…		
Diabetes?		
High Blood Pressure?		
Glaucoma?		
Have you ever received…		
Pneumonia Vaccine?		
Year received?		

Cancer (note type, location & year):

☐ None

Other Chronic Problems (describe):

☐ None

PLEASE TURN PAGE → →

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

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

Prior Eye Surgery:	**Cataract Surgery**	**Glaucoma Surgery**	**Retina Surgery**
Right Eye	Year:_____	Year:_____	Year:_____
Left Eye	Year:_____	Year:_____	Year:_____

Other Surgery (list type and year)**:**

☐ None ☐ See Attached List

Family History of Eye Disease:

Cataracts	?	No	Yes	Family Member:_____
Macular Degeneration	?	No	Yes	Family Member:_____
Retinal Detachment	?	No	Yes	Family Member:_____
Diabetes	?	No	Yes	Family Member:_____
Glaucoma	?	No	Yes	Family Member:_____

Other:_____

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_____

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: We have posted in the lobby and available at the front desk a Privacy Notice that 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