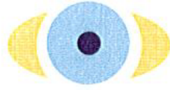

GOODMAN
EYE • CENTER

Patient Demographic/Intake Form

Salutation: Dr./Mr./Mrs./Ms./Miss

Last Name	First Name	Middle Name

Date of Birth ______________________

Gender: •Male •Female •Other: ______________

Street Address	City	State	Zip Code

Cell Phone	Home Phone	Email Address

Preferred mode of contact:	Race:	Ethnicity:
• Cell phone – call	• American Indian/Alaska Native	• Hispanic or Latino
• Cell phone – text	• Asian	• Not Hispanic or Latino
• Home Phone	• Black or African American	• Decline to answer
• Email	• Native Hawaiian or Other Pacific Islander	
	• White	
	• Other:__________	
	• Decline to answer	

Occupation	Employer	Work Phone

Emergency Contact Person	Emergency Contact Phone	Relation to Emergency Contact

Legal Guardian (if under 18)	Legal Guardian's Contact Phone	Relation to Legal Guardian

Whom May We Thank for this Referral?

• Doctor: ______________________________ • Google/Facebook/Yelp

• Friend: ______________________________ • Other: ______________________________

Reason for Appointment: ____

2211 Bush Street • Second Floor • San Francisco CA 94115-3121

T 415-474-3333 • F 415-474-3939 • goodmanEYEcenter.com

Medical History Questionnaire

____
Referring Doctor Name and Location

____
Primary Care Doctor Name and Location

____
Eye Physician Name and Location

____
Pharmacy Name and Address

Allergies: ◻ None

______________ ______________ ______________

Past Ocular History: (Please mark all that apply) ◻ No history of eye problems

◻ Amblyopia (Lazy Eye)
◻ Astigmatism
◻ Cataracts
◻ Corneal Disorder
◻ Diabetic Retinopathy
◻ Dry Eye Syndrome
◻ Glaucoma
◻ Hyperopia (Farsighted)
◻ Iritis/Uveitis
◻ Keratoconus
◻ Macular Degeneration
◻ Myopia (Nearsighted)
◻ Retinal Detachment
◻ Trauma/Injury
◻ Other: ____

Ocular Surgeries: (Please mark all that apply) ◻ No prior ocular surgery

R - L
◻ ◻ Blepharoplasty (Lid Surgery)
◻ ◻ Cataract Surgery
◻ ◻ Corneal Transplant

R - L
◻ ◻ Glaucoma Surgery
◻ ◻ LASIK/PRK
◻ ◻ Retinal Surgery

R - L
◻ ◻ Strabismus Surgery
◻ ◻ Vitrectomy
◻ ◻ YAG Laser Capsulotomy

Other: ____

Current Eye Medications: (Please list)

Name	How much and how often?

Other Medical History: ◻ No history of illnesses

◻ Acid Reflux/GERD
◻ ADHD
◻ Anemia
◻ Anxiety/Depression
◻ Arthritis
◻ Arrhythmia
◻ Asthma
◻ Cancer
◻ Congestive Heart Failure
◻ COPD
◻ Diabetes (Type 1 or Type 2)
◻ Fibromyalgia
◻ Currently pregnant or breastfeeding
◻ Headache
◻ Hearing Loss
◻ Heart Attack
◻ Hepatitis
◻ Herpes
◻ High Blood Pressure
◻ High Cholesterol
◻ HIV/AIDS
◻ Keloid Formation
◻ Kidney Disease
◻ Liver Disease
◻ Lupus
◻ Lyme Disease
◻ Migraine
◻ Multiple Sclerosis
◻ Polymyalgia Rheumatica
◻ Rosacea/Dermatitis
◻ Rheumatoid Arthritis
◻ Sarcoidosis
◻ Sickle Cell Disease
◻ Stroke
◻ STD
◻ Thyroid Disease
◻ Tuberculosis

Other____

General Surgeries/Procedures: (Please list and date)

All Other Medications: (Please list)

Name	How much and how often?	What for?

Family History: (Please indicate relationship) □ No history of illnesses □ History unknown

□ Blindness □ Glaucoma □ Macular Degeneration
□ Cancer □ Heart Disease □ Retinal Disease
□ Cataracts □ High Blood Pressure □ Stroke
□ Diabetes □ Lazy Eye □ Other___________________________

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker
□ former smoker □ never smoked

Alcohol Use: □ No □ Yes If yes, how much and how often? ________________________________

Drug Use: □ No □ Yes If yes, which and how long? _____________________________________