

Patient Demographic/Intake Form

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

Last Name	First Name	Middle Name			
	Gender: □Male □Female □Other:				
Date of Birth					
Street Address	City	State Zip Code			
Cell Phone	Home Phone	Email Address			
Preferred mode of contact:	Race:	Ethnicity:			
□ Cell phone – call □ Cell phone – text □ Home Phone □ Email	☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other: ☐ Decline to answer	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ 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 R □ Doctor:	Referral?	Yelp			
□ Friend:					
Reason for Appointment:					

Medical History Questionnaire

Referring Doctor Name and Lo	ocation		
Primary Care Doctor Name and	d Location		
Eye Physician Name and Loca	tion		
Pharmacy Name and Address			
Allergies: None			
Past Ocular History: (Please ☐ Amblyopia (Lazy Eye) ☐ Astigmatism ☐ Cataracts ☐ Corneal Disorder ☐ Other:	 □ Diabetic Retinopathy □ Dry Eye Syndrome □ Glaucoma □ Hyperopia (Farsighted) 	□ Iritis/Uveitis□ Keratoconus□ Macular Degeneration	□ Retinal Detachment □ Trauma/Injury eration ghted)
Ocular Surgeries: (Please ma R - L	rk all that apply)	R - L gery	tomy
Name	How much and how	often?	
Other Medical History: □ N □ Acid Reflux/GERD □ ADHD □ Anemia □ Anxiety/Depression □ Arthritis □ Arrhythmia □ Asthma □ Cancer □ Congestive Heart Failure □ COPD □ Diabetes (Type 1 or Type 2) □ Fibromyalgia	o history of illnesses	□ Mig □ Mul □ Poly □ Rosa ssure □ Rhe □ Sarc □ Sick □ STD □ Thys	raine tiple Sclerosis rmyalgia Rheumatica acea/Dermatitis umatoid Arthritis roidosis ale Cell Disease ke oroid Disease
☐ Currently pregnant or breasts	feeding		

General Surg	eries/Procedures: (Ple	ase list ar	nd date)		
Name	dications: (Please list)		ch and how often?	What for?	
Family Histor	ry: (Please indicate rel	ationship) □ No history of illnesses	S	□ History unknown
Blindness	□ Glaucoma		□ Macular Dege		
□ Cancer	□ Heart Dise		□ Retinal Diseas	e	
Cataracts		d Pressure			
□ Diabetes	□ Lazy Eye		□ Other		
Social History	: (Please mark all tha	t apply)			
	□ current every day s	moker	□ current some day smol	ker	
A 1 1 1 T T .	□ former smoker	16	never smoked		
Alcohol Use:	□ No □ Yes	If yes,	how much and how often?	·	
Orug Use:	⊔ NO □ Yes	II yes,	which and how long?		