

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	Emergency Contact Phone Relation to Emergency Contact		
Legal Guardian (if under 18)	Legal Guardian's Contact Phone	Relation to Legal Guardian		
*****		7.1		
Whom May We Thank for this		/ alm		
Doctor:	U Google/Facebook/Y	тегр		

Medical History Questionnaire

Referring Doctor Name an	d Location		
Primary Care Doctor Nam	e and Location		
Eye Physician Name and I	Location		
Pharmacy Name and Addr	ress		
Allergies: None			
□ Amblyopia (Lazy Eye) □ Astigmatism □ Cataracts □ Corneal Disorder	ease mark all that apply)	☐ Iritis/Uveitis☐ Keratoconus☐ Macular Degeneration	□ Retinal Detachment □ Trauma/Injury
Ocular Surgeries: (Please R - L □ □ Blepharoplasty (Lid S □ □ Cataract Surgery □ □ Corneal Transplant	e mark all that apply) $\qquad \qquad \square \ \mathrm{N}$ R - L	R - L gery	ismus Surgery ctomy Laser Capsulotomy
Current Eye Medications Name	S: (Please list) How much and how	v often?	
Contact Lens History: □ No contact lens wear			
□ Rigid Gas Permeable (R	GP)		
□ Scleral lenses			
□ Soft lenses Brand and	power if known:		
□ Other:			
	orn:		

	Iistory: □ No hist	ory of illnesses	S			
□ Acid Reflux/GERD		☐ Headache			□ Lyme Disease	
□ ADHD			☐ Hearing Loss		□ Migraine	
□ Anemia			□ Heart Attack		□ Multiple Sclerosis	
□ Anxiety/Depre	ssion	□ Hepa			□ Polymyalgia Rheumatica	
□ Arthritis			□ Herpes		□ Rosacea/Dermatitis	
•			Blood Pressure		□ Rheumatoid Arthritis	
□ Asthma			Cholesterol		□ Sarcoidosis	
□ Cancer		□ HIV/			☐ Sickle Cell Disease	
□ Congestive Hea	art Failure		d Formation		□ Stroke	
□ COPD		□ Kidney Disease			□ STD	
□ Diabetes (Type	1 or Type 2)		Disease		☐ Thyroid Disease	
□ Fibromyalgia		□ Lupu	S		□ Tuberculosis	
	nant or breastfeedin	g				
Other						
General Surgeri	es/Procedures: (Pl	ease list and d	late)			
All Other Medic Name	rations: (Please list	•	nd how often?	What for?		
				·		
		-				
Family History	(Please indicate re	olotionshin) =	No history of illne	aggag	□ History unknown	
□ Blindness	☐ Glaucoma	A '	□ Macular D		□ Thistory unknown	
□ Cancer	□ Heart Dise		□ Retinal Dis			
□ Cataracts	□ High Bloc	od Pressure	□ Stroke			
□ Diabetes	□ Lazy Eye					
Coolal III:stawer	Dloogo mayle all 41-	ot annl)				
Smoking:	Please mark all the current every day	smoker \square	current some day s	moker		
	former smoker		never smoked			
		If yes, how	w much and how of	ten?		
Drug Use:	□ No □ Yes	If yes, wh	ich and how long?			