Jay S. Folkman, O.D., PC.

**How did you find out about us?** ❑ Insurance ❑ Internet ❑ Patient Referral (list name) _____

Patient's Legal Name _____ Marital Status ❑ **M** ❑ **S** ❑ **D** ❑ **W**

Nickname_____ Ethnicity ❑ Hispanic/Latino ❑ Non-Hispanic ❑ Native Hawaiian/Islander

DOB_____/_____/_____SSN#_____ Race ❑ American Indian/Alaskan Native ❑ Asian ❑ African American

Address_____ ❑ Hispanic/Latino ❑ Native Hawaiian/Pacific Islander ❑ White

City _____ State _____ Zip _____ Employer _____

Home Phone _____ Occupation _____

Cell Phone _____ Primary Care Provider_____

Work Phone _____ PCP Phone _____

Email _____ Last Eye Exam _____

Pharmacy _____ Location_____

Please list **ALL** Insurance plans you are covered under _____

Emergency Contact _____Relationship_____Phone_____

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RESPONSIBLE PARTY & INSURANCE INFO. (IF DIFFERENT FROM ABOVE OR PATIENT IS A MINOR)

First Name: _____Last Name:_____ SSN:_____

DOB: ____ /____ /_____ Day Phone:_____ Cell Phone:_____ Work Phone:_____

Address:_____City:_____State:_____ Zip:_____

For your privacy, please mark the manner in which we may contact you: ❑Home Phone ❑ Cell (Ok to text?) ❑**Y** ❑ **N** ❑ Work Phone ❑ Email

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## Past Medical History (mark yes or no)

Do you currently have, or previously had any of the following problems or conditions?

| | Yes | No |
|---|---|---|
| **Cardiovascular** | | |
| **Arrhythmia** | ❑ | ❑ |
| **Elevated Cholesterol** | ❑ | ❑ |
| **Heart Attack** | ❑ | ❑ |
| **High Blood Pressure** | ❑ | ❑ |
| **Stroke** | ❑ | ❑ |
| **Endocrine** | | |
| **Diabetes Type I** | ❑ | ❑ |
| **Diabetes Type II** | ❑ | ❑ |
| **Diabetic Suspect** | ❑ | ❑ |
| **Last date and A1c, if known:** _____ | | |
| **Gout** | ❑ | ❑ |
| **Hypothyroidism** | ❑ | ❑ |
| **Hyperthyroidism** | ❑ | ❑ |
| **Hashimoto's Disease** | ❑ | ❑ |
| **Gastrointestinal** | | |
| **Crohn's Disease/Colitis** | ❑ | ❑ |
| **Hepatitis A / B / C** | ❑ | ❑ |
| **Irritable Bowel Syndrome** | ❑ | ❑ |
| **Ulcer / Reflux /GERD** | ❑ | ❑ |

| | Yes | No |
|---|---|---|
| **Genito-Urinary** | | |
| **Bladder Urgency/Frequency** | ❑ | ❑ |
| **Herpes Simplex** | ❑ | ❑ |
| **Prostate Disorder** | ❑ | ❑ |
| **Prostate Cancer** | ❑ | ❑ |
| **Ears/Nose/Mouth/Throat** | | |
| **Hearing Loss** | ❑ | ❑ |
| **Hematologic / Lymphatic** | | |
| **Anemia** | ❑ | ❑ |
| **Breast Cancer** | ❑ | ❑ |
| **Bleeding Disorder** | ❑ | ❑ |
| **Immunologic** | | |
| **AIDS** | ❑ | ❑ |
| **HIV Positive** | ❑ | ❑ |
| **Organ transplant** | ❑ | ❑ |
| **Sjögren's syndrome** | ❑ | ❑ |
| **Integumentary (skin)** | | |
| **Skin Cancer** | ❑ | ❑ |
| **Lupus** | ❑ | ❑ |

| | Yes | No |
|---|---|---|
| **Musculoskeletal** | | |
| **Chronic Pain** | ❑ | ❑ |
| **Joint / Muscle Pain** | ❑ | ❑ |
| **Osteo Arthritis** | ❑ | ❑ |
| **Rheumatoid Arthritis** | ❑ | ❑ |
| **Neurological** | | |
| **Migraines** | ❑ | ❑ |
| **Multiple Sclerosis** | ❑ | ❑ |
| **Parkinson's Disease** | ❑ | ❑ |
| **Seizure Disorder** | ❑ | ❑ |
| **Psychiatric** | | |
| **Anxiety / Depression** | ❑ | ❑ |
| **Attention Disorder** | ❑ | ❑ |
| **Bipolar** | ❑ | ❑ |
| **PTSD** | ❑ | ❑ |
| **Respiratory** | | |
| **Asthma** | ❑ | ❑ |
| **Chronic Bronchitis** | ❑ | ❑ |
| **Emphysema** | ❑ | ❑ |
| **Sleep Apnea** | ❑ | ❑ |
| **COPD** | ❑ | ❑ |

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## Social History

**Tobacco Use** (mark which one applies)

❑ Never a smoker ❑ Light tobacco smoker ❑ Everyday smoker Packs/Day:

❑ Former smoker Year quit? _____ ❑ Smokless tobacco user Years? _____ _____

**Alcohol** ❑ No ❑ Yes If so, frequency _____



**Please Complete Both Sides of the Form** →

## Miscellaneous

List **ANY** previous surgeries with dates and other medical issues:

_____

_____

_____

_____

_____

_____

## Ocular History (mark yes or no to each question)

| | | |
|---|---|---|
| **Age-Related Macular Degeneration** | ❑ Yes | ❑ No |
| **Amblyopia (Lazy eye)** | ❑ Yes | ❑ No |
| **Bindness** | ❑ Yes | ❑ No |
| **Cataracts** | ❑ Yes | ❑ No |
| **Cataract Surgery** | ❑ Yes | ❑ No |
| **Date:** _____ | | |
| **Glaucoma** | ❑ Yes | ❑ No |
| **Injury to the eye region** | ❑ Yes | ❑ No |
| **Keratoconus** | ❑ Yes | ❑ No |
| **Refractive Surgery (Lasik, PRK)** | ❑ Yes | ❑ No |
| **Retinopathy** | ❑ Yes | ❑ No |
| **Strabismus (Crossed eyes)** | ❑ Yes | ❑ No |
| **Tear film insufficiency (dry eyes)** | ❑ Yes | ❑ No |

**Other:** _____

## Medications

❑ No Medications

List prescriptions, over-the-counter, eye drops and dosages for each.

_____

_____

_____

_____

_____

## List Medication Allergies

❑ No Medication Allergies

_____

_____

_____

## Family Health History (mark yes or no to each question)

If yes, list which family member including mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather)

| | | | | | |
|---|---|---|---|---|---|
| **Amblyopia (Lazy eye)** | ❑ Yes | ❑ No _____ | **Cancer** | ❑ Yes | ❑ No _____ |
| **Blindness** | ❑ Yes | ❑ No _____ | **Diabetes Mellitus** | ❑ Yes | ❑ No _____ |
| **Cataract** | ❑ Yes | ❑ No _____ | **Heart disease** | ❑ Yes | ❑ No _____ |
| **Cataract surgery** | ❑ Yes | ❑ No _____ | **Hypertension (high blood pressure)** | ❑ Yes | ❑ No _____ |
| **Glaucoma** | ❑ Yes | ❑ No _____ | **Stroke** | ❑ Yes | ❑ No _____ |
| **Macular Degeneration** | ❑ Yes | ❑ No _____ | | | |
| **Strabismus (cross eyes)** | ❑ Yes | ❑ No _____ | | | |
| **Retinal disorder** | ❑ Yes | ❑ No _____ | | | |

**Other:** _____

_____

## Acknowledgment of Notice of Privacy Practices

The law requires that Jay S. Folkman, O.D., P.C. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

__ I was given the opportunity to read, have read or had explained to me Jay S. Folkman, O.D., P.C.'s Notice of Privacy Practice prior to any services offered.

___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

I authorize Jay S. Folkman, O.D., P.C. to release my personal health information to the following individuals:

_____ _____ _____

**I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.**

Signature: _____ Date: _____

If you are signing as a personal representative of the patient, please indicate your relationship:

_____ _____

Representative Signature Relationship to Patient