Jay S. Folkman, OD, 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 ❑ Hispanic/Latino ❑ Native Hawaiian/Pacific Islander ❑ White

Address ____________

City ____________ State ________ Zip ________ Employer ____________

Home Phone ____________ Occupation ____________

Cell Phone ____________ Primary Care Provider ____________

Work Phone ____________ PCP Phone ____________

Last Eye Exam ____________

Email ____________ Pharmacy ____________ Location ____________

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

Emergency Contact ____________ Relationship ____________ Phone ____________

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?

Condition	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	❑	❑

Condition	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	❑	❑

Condition	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	❑	❑

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**	____________
Blindness	❑ **Yes**	❑ **No**	____________
Cataract	❑ **Yes**	❑ **No**	____________
Cataract surgery	❑ **Yes**	❑ **No**	____________
Glaucoma	❑ **Yes**	❑ **No**	____________
Macular Degeneration	❑ **Yes**	❑ **No**	____________
Strabismus (cross eyes)	❑ **Yes**	❑ **No**	____________
Retinal disorder	❑ **Yes**	❑ **No**	____________
Cancer	❑ **Yes**	❑ **No**	____________
Diabetes Mellitus	❑ **Yes**	❑ **No**	____________
Heart disease	❑ **Yes**	❑ **No**	____________
Hypertension (high blood pressure)	❑ **Yes**	❑ **No**	____________
Stroke	❑ **Yes**	❑ **No**	____________

Other: ____

____

Acknowledgment of Notice of Privacy Practices

The law requires that Jay S. Folkman OD, PC. 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 OD, PC'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 OD, PC 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