Jay S. Folkman, OD, PC

How did you find out about us? ☐ Insurance ☐ Internet ☐ Patient Referral (list name) ______________________

Patien'ts 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______________

Emergency Contact ______________________Relationship______________Phone______________

Please list ALL Insurance plans you are covered under ______________________

For your privacy, please indicate the manner in which we may contact you:
☐ Mail ☐ Home Phone ☐ Work ☐ Phone ☐ Cell Phone (Okay to text? ☐ Y ☐ N) ☐ E-Mail

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RESPONSIBLE PARTY & INSURANCE INFO. (IF DIFFERENT FROM ABOVE OR PATIENT IS A MINOR)
First Name: ______________________ Last Name:______________________

SSN:______________________ DOB: ______ /______ /______

Phone Numbers: Home:______________ Work: ______________ Cell:______________

Address:______________________City:______________State:________Zip:__________

Review of Systems (mark yes or no to each question)

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

Cardiovascular	Yes	No
Heart Attack	☐	☐
High Blood Pressure	☐	☐
High Cholesterol Stroke	☐	☐
Vascular Disease	☐	☐
	☐	☐

Ears/Nose/Mouth/Throat	Yes	No
Sinus Congestion	☐	☐
Hearing Loss	☐	☐

Endocrine	Yes	No
Diabetes Type I	☐	☐
Diabetes Type II	☐	☐
Gout	☐	☐
Hypothyroidism	☐	☐
Hyperthyroidism	☐	☐
Hashimoto's disease	☐	☐

Gastrointestinal	Yes	No
Crohn's Disease	☐	☐
Hepatitis A / B / C	☐	☐
Irritable Bowel Syndrome	☐	☐
Ulcer / Reflux /GERD	☐	☐

Genito-Urinary	Yes	No
Bladder Urgency/Frequency	☐	☐
Herpes Simplex	☐	☐
Prostate Disorder	☐	☐

Musculoskeletal	Yes	No
Chronic Pain	☐	☐
Joint / Muscle Pain	☐	☐
Osteo Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐

Integumentary (skin)	Yes	No
Skin Cancer	☐	☐
Skin Disease	☐	☐
Lupus		

Neurological	Yes	No
Headaches	☐	☐
Migraines	☐	☐
Multiple Sclerosis	☐	☐
DUNLVRVLVHDVH	☐	☐
SeizureLVRUGHU	☐	☐

DgmW\]Uhf]W`	Yes	No
Anxiety / Depression		

@madU\h]W'Ë<YaUhc`c[]W`	Yes	No
Anemia	☐	☐
Bleeding Problems	☐	☐

,PPRORJLF	Yes	No
AIDS	☐	☐
HIV Positive	☐	☐
Organ transplant	☐	☐
Sjögren's syndrome	☐	☐

Miscellaneous

List ANY previous surgeries with dates and other medical issues:

____

____

____

Respiratory	Yes	No
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Sleep Apnea	☐	☐
COPD	☐	☐

Please Complete Both Sides of the Form OVER →

Ocular History (mark yes or no to each question)

Condition	Yes	No	Condition	Yes	No
Age-related macular degeneration	❑ Yes	❑ No	Injury to the eye region	❑ Yes	❑ No
Amblyopia (Lazy eye) Blindness-one eye	❑ Yes	❑ No	Keratoconus	❑ Yes	❑ No
Bindness-both eyes	❑ Yes	❑ No	Retinopathy	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No	Strabismus (Crossed eyes)	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	Tear film insufficiency (dry eyes)	❑ Yes	❑ No
History of refractive surgery	❑ Yes	❑ No	Other ______________________________		
	❑ Yes	❑ No	______________________________		

Patient's Past Medical History (mark yes or no to each question)

Condition	Yes	No	Condition	Yes	No
Acquired Immune Deficiency Syndrome (AIDS)	❑ Yes	❑ No	Human immunodeficiency virus infection (HIV)	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Hypercholesterolemia (High cholesterol)	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Hypertensive disorder (Hypertension)	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Seasonal allergy	❑ Yes	❑ No
Chronic obstructive lung disease (COPD)	❑ Yes	❑ No	Thyroid dysfunction	❑ Yes	❑ No
Diabetes mellitus	❑ Yes	❑ No	Mental disorder	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Rheumatoid arthritis	❑ Yes	❑ No
Heart disease	❑ Yes	❑ No	Other ______________________________		
			______________________________		

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)

Condition	Yes	No	Condition	Yes	No
Amblyopia (Lazy eye)	❑ Yes	❑ No ____________	Strabismus (cross eyes)	❑ Yes	❑ No ____________
Blindness and/or vision impairment	❑ Yes	❑ No ____________	Arthritis	❑ Yes	❑ No ____________
Cataract	❑ Yes	❑ No ____________	Cancer	❑ Yes	❑ No ____________
Macular Degeneration	❑ Yes	❑ No ____________	Diabetes mellitus	❑ Yes	❑ No ____________
Glaucoma	❑ Yes	❑ No ____________	Hypertension (high blood pressure)	❑ Yes	❑ No ____________
Retinal disorder	❑ Yes	❑ No ____________	Cardiovascular disease	❑ Yes	❑ No ____________
			Stroke	❑ Yes	❑ No ____________

Social History (check one for each question)

Alcohol ❑ No ❑ Yes If so, frequency ____________________

Tobacco Use (mark which one applies)

❑ Never a smoker ❑ Light tobacco smoker
❑ Smokeless tobacco ❑ Former smoker

Medications

❑ No Medications

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

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____
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Medication Allergies

❑ No Medication Allergies

List any allergies you may have and reaction.

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ACKNOWLEDGEMENT OF RECEIPT OF HIPPA Form (Privacy Policy)

I acknowledge that I have access to a copy of the Privacy Practice, Jay S. Folkman, O.D.

Signature: ______________________________ Date: ____________________