OFFICE PORTION

PATIENT NAME: PT ID# DOB: DOS:

INSURANCES:

ROUTINE MEDICAL CODES IF MEDICAL:

PT TO RETURN IN: _____ DAY(S) _____ WEEK(S) _____ MONTH(S) _____ YEAR

RETURN FOR: CEE CL EVAL CL F/U MED F/U OCT PHOTOS VISUAL FIELD

PATIENT PORTION

Name: _____ DOB: _____

Primary Care Physician: _____ When was your last physical? _____

Pharmacy Name and Location: _____

Are you allergic to any medications, foods, latex, or dyes? _____

What medical conditions do you have? _____

_____

May we electronically import prescriptions from your pharmacy? Yes/No

What medications or supplements are you taking? _____

_____

Are there any other changes to your health? _____

_____

Please circle all that apply:

Poor Vision	Cough	Rash/Hives	Rapid Heartbeat
Eye Pain	Congestion	Changing Moles	Anemia
Tearing	Wheezing	Allergies	High Blood Pressure
Red eye	Shortness of breath	Hay Fever	Bleeding
Temporary vision loss	Headache	Arthritis	Thyroid Abnormalities
Fever/Chills	Jaw pain/Scalp tenderness	Joint Pain/Stiffness	Diabetes
Stuffy nose	Seizure	Upset Stomach	Insomnia
Ear ache	Stroke	Diarrhea	Urinary Frequency
Weight loss	Paralysis	Constipation	Burning on Urination
Dry mouth	Anxiety/ Depression	Incontinence	

Please indicate all that apply:

Allergic to Adhesives or Lidocaine?	Yes or No
Using Blood Thinners or Flomax?	Yes or No
Have a Pacemaker, Defibrillator, or Artificial heart valve?	Yes or No
Have you been exposed to or had Ebola or MRSA?	Yes or No
Pregnant or planning to become pregnant?	Yes or No
Are you pre-medicating for any upcoming surgeries?	Yes or No

Signature: _____ Date: _____