Welcome to

Dr. Kim E. Mauro, OD and Associates, LLC

Patient Information

Today's Date:		
Name:	DOB (date of birth):	
Address:		
City:	State:	Zip Code:
Email Address:	Phone:	
Employer:	Occupation:	Work Phone:

Insurance Information

Insurance name:	ID #:	Plan #:
Insured's Name:	Insured's DOB:	Relationship to PT:

Medical and Ocular History

What is the reason for today's examination? (please circle all that apply)

Routine Check Up	New Eye Glass Prescription	New Contact Lens Prescription	Eye Problem	Dilated Retinal Examination

other reason:

Do you or any of your blood relatives (I.E. grandparents, parents, siblings) have any of these conditions?

Condition	Self	Relative	None	Condition	Self	Relative	None
Diabetes				Retinal Disease			
High Blood Pressure				Eye Surgery			
Thyroid Problems				Macular Degenration			
Asthma				Cataracts			
Cancer				Glaucoma			
High Cholesterol				Eye Injury			
Allergies				Dry eyes			
Seizures				Crossed Eyes			
Do you see double? (Please circle)		Yes	No	Do you have frequent headaches?		Yes	No

Please list ALL prescription or over the counter medication INCLUDING eyedrops, vitamins and supplements:

Please list ALL allergies (medical, seasonal, other):