

Patient Form



Exam Date: \_\_\_\_\_

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Doctor/ Single/ Married/ Male/ Female

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Occupation: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Contact: Home / Work / Cell

Race: White/Black/American Indian/Asian/Other: \_\_\_\_\_ Ethnicity: Hispanic/Non-Hispanic

Language (preferred): English/Mandarin/Cantonese/Spanish/Hindi/Russian/Other: \_\_\_\_\_

Guardian Name: \_\_\_\_\_ Father/Mother/Grandparent/Other/M/ F

Reason for Visit: \_\_\_\_\_ Refer by: \_\_\_\_\_

Leisure Activities: \_\_\_\_\_

Eye History month / day / year Vision Ins: \_\_\_\_\_ SS/ID: \_\_\_\_\_

Last Eye Exam: \_\_\_\_\_ Eye Care Physician: \_\_\_\_\_

<u>Circle all that apply:</u>	Self	Family	If yes, relationship, when, type, and treatment?
Glaucoma.	Yes / No	Yes / No	_____
Cataract	Yes / No	Yes / No	_____
Macular Degeneration	Yes / No	Yes / No	_____
Dry Eyes	Yes / No	Yes / No	_____
Floaters	Yes / No	Yes / No	_____
Blurred Vision	Yes / No	Yes / No	_____
Eye Injury	Yes / No	Yes / No	_____
Surgery (ie, C-section)	Yes / No	Yes / No	_____
Hypertension	Yes / No	Yes / No	_____
Diabetes	Yes / No	Yes / No	_____
Cholesterol	Yes / No	Yes / No	_____

Other Eye Conditions: \_\_\_\_\_

Medical History month / day / year Health Ins: \_\_\_\_\_ ID: \_\_\_\_\_

Last Health Exam: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Describe any problems and Medications: \_\_\_\_\_ Flex Spending \_\_\_\_\_

Do you have problems with any of these systems? (Please check all that apply.):

- |   |   |   |
|---|---|---|
| Allergic/Immunologic <input type="checkbox"/> | Endocrine <input type="checkbox"/>        | Integumentary (Skin) <input type="checkbox"/> |
| Cardiovascular <input type="checkbox"/>       | Gastrointestinal <input type="checkbox"/> | Musculoskeletal <input type="checkbox"/>      |
| Constitutional <input type="checkbox"/>       | Genitourinary <input type="checkbox"/>    | Neurological <input type="checkbox"/>         |

Please turn off cell phone prior entering the exam room.

It is a pleasure to serve you and your family here at Vision 27.