

PATIENT INFORMATION

Personal

Name _____ Social Security # _____
Driver's License Number _____ Birth Date _____
Address _____ City _____
State _____ Zip Code _____ Home Phone _____
Business Phone _____ Cell Phone _____
Name of Parent or Spouse _____
Have we examined other members of your family? ____ Yes ____ No
If yes, whom? _____

Employment

Occupation _____ Employer _____
Grade if Student _____ School _____
Do you use a computer? ____ No ____ Yes: How many hours per day? _____

Method of Payment

Medicare ____ Medicaid ____ Check ____ Cash ____ Credit Card ____
Vision Service Plan ____ Superior Vision ____ Other Insurance _____

Medical and/or Vision Insurance

Insurance Company _____ Policy Number _____
Medicare Number _____ Medicaid Number _____
Supplemental Insurance _____ Policy # _____
Name & Address of Family Physician _____ Name & Address of Last Eye Doctor _____

How Did You Find Out About Our Office?

Yellow Pages ____ Location ____ Radio ____ Family Doctor ____
Newspaper ____ Mailouts ____ Television ____ Insurance Company ____
Referred By: (name) _____

MEDICAL HISTORY / REVIEW of SYSTEMS

Name _____ Occupation _____ Date _____

MEDICAL HISTORY

DOB _____

What is your general health status? ___ Excellent ___ Good ___ Fair ___ Poor

List all medications you are taking. _____

Do you have allergies to any medications? ___ Yes ___ No If yes, explain: _____

Do you have general allergies? ___ Yes ___ No Allergic to what? _____

What happens? _____

List all major illnesses, injuries, surgeries and/or hospitalizations within the last 10 years. _____

Are you pregnant? ___ Yes ___ No If yes, how many months? _____

OCULAR HISTORY

Date of last eye examination. _____ Do you wear eyeglasses? ___ Yes ___ No

Do you wear contact lenses? ___ Yes ___ No If yes, what type? _____

Current eyedrops _____

List all current or past eye diseases, eye injuries, or eye surgeries. _____

FAMILY HISTORY

Please circle **Yes** or **No** to indicate if any member of your family has had these diseases.

(Family history includes your parents, grandparents, siblings, and your children.)

Relationship To You

Blindness	yes / no	_____
Cataract	yes / no	_____
Glaucoma	yes / no	_____
Diabetes	yes / no	_____
High Blood Pressure	yes / no	_____
Cancer	yes / no	_____
Heart Disease	yes / no	_____
Thyroid Disease	yes / no	_____
Arthritis	yes / no	_____
Stroke	yes / no	_____
Macular Degeneration	yes / no	_____
Other Inherited Disease		_____

SOCIAL HISTORY

(This information is a protected part of your medical record. It is confidential.

However, if you prefer, you may discuss this portion of your medical history directly with the doctor.)

Does your vision limit activities of daily living? (driving, reading, working, etc) ___ Yes ___ No

If yes, please describe. _____

Marital Status ___ Single ___ Married ___ Divorced ___ Widow / Widower

Living Arrangements ___ Live by Yourself ___ Live w/ Spouse
 ___ Live w/ Parents ___ Live w/ Children
 ___ Assisted Living ___ Nursing Home ___ Other

Employment Status ___ Employed ___ Self-Employed ___ Retired
 ___ Homemaker ___ Medical Disability ___ Unemployed

Do you use tobacco products? ___ Yes ___ No If yes, packs per week? _____

Do you drink alcohol? ___ Yes ___ No If yes, amount and how often? _____

Do you use illegal drugs? ___ Yes ___ No If yes, what type? _____

Please put a **check** next to the following **if you have ever been exposed to or infected with**:

___ HIV ___ Hepatitis ___ Tuberculosis ___ Chlamydia ___ Gonorrhea

REVIEW of SYSTEMS

Please **circle Yes or No** to indicate if **you** currently have any problems in one or more of the following areas?
If yes, please explain or describe the problem.

GENERAL / CONSTITUTIONAL **Yes / No**
(fever, weight loss or gain, tired feeling) _____

EYES **Yes / No**
(blurred vision, eye pain, discharge, etc) _____

EARS, NOSE, THROAT, MOUTH **Yes / No**
(hearing loss, ear ache, nasal congestion, chronic cough, nasal drip, dry mouth, allergies, hay fever, etc.) _____

RESPIRATORY **Yes / No**
(asthma, emphysema, chronic bronchitis, wheezing, shortness of breath, etc.) _____

CARDIOVASCULAR **Yes / No**
(diabetes, hypertension, heart problems) _____

GASTROINTESTINAL **Yes / No**
(diarrhea, constipation, hernia, ulcers, etc.) _____

GENITOURINARY **Yes / No**
(painful urination, frequent urination, impotence, jaundice, etc.) _____

LYMPHATIC **Yes / No**
(anemia, bleeding problems, problems with blood transfusions, etc.) _____

MUSCULOSKELATAL **Yes / No**
(arthritis, joint pain, muscle pain, cramps, stiffness, swelling. etc.) _____

SKIN **Yes / No**
(pimples, warts, growths, rashes, etc.) _____

Austin Ruiz, O.D. _____

Date _____