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) _____

GASTROINTENSTINAL **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.) _____

Herman H. Gerdes, III, O. D._____ Date_____