**PATIENT INFORMATION**

## PART I: Patient Profile

First Name_____ MI _____ Last Name_____

Best Phone No._____ PHONE TYPE: ☐ CELL ☐ HOME ☐ WORK

Date of Birth _____/_____/_____ Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Race: _____ Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin

Mailing Address _____ City _____ State _____ Zip Code_____

SS #_____Employer_____ Occupation: _____

Work Phone _____ E-mail_____

*** We use your email to notify you of your appointments. It is kept confidential and private.**

**Guardian Information:** **(if patient is 17 years of age or younger):** ☐ **Check the box if contact information is the same as above**

First Name_____ MI _____ Last Name: _____

Best Phone No. _____ PHONE TYPE: ☐ CELL ☐ HOME ☐ WORK

Date of Birth ____/_____/_____ Relationship to Patient_____

Employer: _____ Occupation: _____Work Phone _____

Mailing Address _____City_____ State_____ Zip Code_____

Guardian E-mail:_____ Are you a patient of ours? ☐ YES ☐ NO

**Emergency Contact:**

**Name:** _____ Relation: _____ Phone No._____

**Who/what referred you to our office today**?

☐ Friend ☐ Family Member ☐ Advertisement ☐ Website ☐ Radio/TV ☐ Insurance ☐ Walk-In ☐ Doctor Referral

Please circle method of payment: Cash Debit Credit Card Care Credit

***We Do Not Accept Checks***

## PART II: Insurance Section

Do you have Vision Insurance? ☐ YES ☐ NO Insurance Name: _____

Do you have Medical Insurance? ☐ YES ☐ NO Insurance Name: _____

Primary Card Holder: **Name:** _____ **DOB**_____ SS: _____

*Thank you for choosing our practice for all your eye care needs.* ☺

# ANGELO EYE CENTER

GENERAL MEDICAL & EYE HISTORY

**Patient Name**: _____ **Age**:_____ **Gender**: Male / Female

1. **List Medications you are allergic to:** _____
2. **History of the following diseases**: *(please Circle Yes or No)*-***Every item must be answered***

| | Self | / Family |
|---|---|---|
| **Respiratory** | | |
| 1. Asthma | Y / N | |
| 2. Bronchitis | Y / N | |
| 3. Emphysema | Y / N | |
| 4. COPD | Y / N | |
| **Cardiac** | | |
| 1. Heart Disease | Y / N | Y / N |
| 2. High Blood Pressure | Y / N | Y / N |
| 3. Low Blood Pressure | Y / N | Y / N |
| 4. High Cholesterol | Y / N | Y / N |
| **Neurological** | | |
| 1. Stroke | Y / N | Y / N |
| 2. Seizure disorder | Y / N | Y / N |

| | Self | / Family |
|---|---|---|
| **Eye Conditions** | | |
| 1. Cataracts | Y / N | Y / N |
| 2. Glaucoma | Y / N | Y / N |
| 3. Macular degeneration | Y / N | Y / N |
| 4. Retinal detachment | Y / N | Y / N |
| **Kidney** | | |
| 1. Renal insufficiency/failure | Y / N | |
| 2. Dialysis dependence | Y / N | |
| **Other Conditions** | | |
| 1. Hepatitis (Type: A B C) | Y / N | |
| 2. Diabetes (Type I or II) | Y / N | Y / N |
| 3. Cancer (Type:_____) | Y / N | Y / N |
| 4. Thyroid (Hyper or Hypo) | Y / N | Y / N |
| 5. STDs | Y / N | |
| 6. Multiple Sclerosis | Y / N | Y / N |
| 7. Arthritis | Y / N | Y / N |
| 8. Skin, Eczema, Rosacea | Y / N | |

3. **Please explain (if necessary) any other medical or eye conditions you might have:**

_____

4. **Have you had any previous eye surgeries ☐ Y or ☐ N:** _____

_____

5. **Do you smoke?** YES or NO How many years? _____ Do you chew tobacco? YES or NO How many years? _____

6. **List your Current Medications: (Prescribed Medicine, Eye drops, Vitamins, Etc.)**

_____

_____

_____

7. **Are you pregnant?** Yes / No

8. **Do you currently suffer from any of the following?** : Please check all that apply to you.

| | | | | | |
|---|---|---|---|---|---|
| Blurry vision | _____ | Burning Eyes | _____ | Flashes of light | _____ |
| Dry eyes | _____ | Headaches | _____ | Eye Pain | _____ |
| Watery eyes | _____ | Floaters | _____ | Other | _____ |
| Itchy Eyes | _____ | Double Vision | _____ | | |

9. **Do you wear glasses or contact lenses?** Yes / No --> If yes to contacts: ☐ Soft ☐ Hard/RGP

10. **Approximate date of last eye exam**: _____ Previous Eye Doctor: _____

**Approximate date of last medical exam**: _____ Current Medical Doctor: _____

11. **Reason for today's visit?** : _____

**Patient Signature** _____ **Date** _____