gileseyecare

Patient Information

Patient Name _____ Date of Birth _____ Sex _____

Mailing Address _____

Phone Number _____ Alternate Number _____

Email _____

SS# _____ Account Responsible (If < 18 y.o.) _____

Marital Status _____ Spouse's Name _____

Occupation _____ [ ] Employed [ ] Student [ ] Other _____

Emergency Contact _____ Phone Number _____

Primary Physician _____ Referred By _____

History

Any serious eye problems or eye surgery in the past? [ ] Yes [ ] No

If yes, please explain: _____

Other Previous Illnesses (w/ approximate dates) _____

Current Medications _____

Allergies to any medications? [ ] Yes _____ [ ] No

Family History (please check and specify relation if applicable)

Glaucoma [ ] _____ Macular Degeneration [ ] _____

Cataracts [ ] _____Heart Disease [ ] Stroke [ ] _____

High Cholesterol [ ] _____ Diabetes [ ] _____

Personal History (Please check the items that apply to you only.)

[ ] Weight Gain or Loss [ ] Unexplained Fatigue [ ] Weakness/Injury (Extremity) [ ] Unexplained Fever

[ ] Shortness of Breath [ ] Irregular Heartbeat [ ] Chest Pain (Angina) [ ] Nose/Throat Problems

[ ] Hard of Hearing [ ] Sinusitis [ ] Frequent Cough [ ] Bronchitis [ ] Emphysema [ ] Asthma

[ ] TB [ ] Frequent Heartburn [ ] Ulcer [ ] Arthritis [ ] Skin Disorder [ ] Eczema/Hives

[ ] Migraine/Headache [ ] Psychiatric Illness [ ] Depression [ ] Anxiety [ ] Alzheimer's

[ ] Tremors [ ] Kidney Disease [ ] Diabetes [ ] Anemia or Swollen Glands [ ] Hay Fever [ ] MS

[ ] Colitis [ ] Parkinson's [ ] Muscular Dystrophy [ ] Hepatitis [ ] Herpes [ ] Enlarged Prostate

[ ] Thyroid Disease [ ] High Blood Pressure [ ] Elevated Cholesterol [ ] Heart Disease [ ] Stroke

[ ] Heart Disease [ ] Heart Attack [ ] Congestive Heart Failure [ ] HIV/AIDS [ ] Cancer

[ ] Other _____

[ ] Alcohol use/ per week _____ Smoking packs/per day _____

Patient Signature: _____ Date: _____

If additional room is needed, please continue on the back.