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) ______________________________________

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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.) ____________________

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

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

Elissa Wedemeyer, O.D. ____________________ Date ____________________

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