

Patient Demographic Information Form

Patient Information

Name: _____ Today's Date: ____/____/____

Preferred Name: _____

Birth Date: ____/____/____ ☐ Male ☐ Female

Age: _____ Height: _____ Weight: _____ Social Security: ____-____-____

Employer/School: _____ Last Eye Exam: ____/____/____

Marital Status: ☐ Married (Spouse Name) _____
☐ Single ☐ Widowed ☐ Divorced

Contact Information

Billing Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Preferred Phone: (____) _____ Alt. Phone: (____) _____

Email for Patient Portal: _____

Insurance Information

Vision Insurance: _____ **Medical Insurance:** _____

Insurance ID # _____ Insurance Policy # _____

Policy Group # _____ Policy Group # _____

Policy Holder Name: _____ Policy Holder Name: _____

• **Review of Systems-** Check all that **currently** apply

☐ Blurred Vision	☐ Poor Night Vision	☐ Total Loss of Vision
☐ Burning	☐ Glare from Headlights	☐ Eyestrain
☐ Double Vision	☐ Itching	
☐ Dryness	☐ Redness	
☐ Eye Pain/Soreness	☐ Watery Eyes	
☐ Floaters	☐ Sandy/Gritty Feeling	
☐ Flashes of Light	☐ Sensitivity to Light	
☐ Matted Eyes/Discharge	☐ Infection of Eye/Eyelid	

Medical History Questionnaire

Please list **all** current medications: _____

Pharmacy: _____ City: _____ State: _____

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list: _____

List **all** major surgeries or injuries you have had: _____

Have you ever been diagnosed with any eye problem or eye diseases? ☐ Yes ☐ No

If yes, please list: _____

Do you smoke? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No

If yes, please list contact lens brand: _____

• **Family History**- Abbreviate **all** that apply:

M=Mother / **F**=Father / **S**=Sister / **B**=Brother / **A**=Aunt / **U**=Uncle / **GM**=Grandmother / **GF**=Grandfather

____ Blindness	____ Diabetes: Type (1) or (2)	____ Heart Disease
____ Cataract	____ Cancer	
____ Glaucoma	____ Thyroid Disease	
____ Macular Degeneration	____ Arthritis	
____ Retinal Detachment	____ High Blood Pressure	

• **Current & Previous Medical Diagnoses**- Check **all** that apply:

Integumentary:

____ Eczema
____ Shingles

Neurological:

____ Migraines
____ Seizures

Endocrine:

____ Thyroid Dysfunction

ENT:

____ Environmental Allergies
____ Sinus Congestion
____ Runny Nose
____ Post-Nasal Drip
____ Chronic Cough
____ Ear/Nose/Throat Problems

Respiratory:

____ Asthma
____ Chronic Bronchitis
____ COPD

Vascular/Cardiovascular:

____ Diabetes: Type (1) or (2)
____ Heart Disease
____ High Blood Pressure

Gastrointestinal:

____ Stomach Issues

Bones/Joints/Muscles:

____ Arthritis / Rheumatoid
____ Muscle Pain
____ Joint Disease

Other:

____ Eye Disease
____ Cancer
____ Multiple Sclerosis
____ Lupus
____ HIV
____ Hepatitis
____ Psychiatric

Lymphatic/Hematologic:

____ Anemia

Neurodevelopmental Disorder:

____ Autism
____ ADHD
____ Nonverbal Learning Disorder