Patient Health Information and Medical History Form

Please Present Insurance Car		
Name	Sex Birth Date	
AddressCity(Wl	Sc	ocial Security Number
City	STZip	<u>Pirangon ditarit dipenorper ai di l</u>
Phone(Home)(Work	(Cell)	(Texting OK: Yes or No)
Employer	Emai	skelonalng to Petient
Employer Date of Last Eye Exam	Name of Doctor	Medical Doctor
[]Glaucoma []Eye Turn In or Out []Eye Disease []Eye Injury []Dry Eyes []Burning, Itching, Redness []Tearing []Light Sensitivity []Double Vision []Tired Eyes []Decreased Vision []Complete Loss of Vision []Heart Disease]High blood Pressure]Breathing/Lung Problem]Cancer]Diabetes]Bleeding Problems]Hepatitis, HIV, TB]Neurological Disease]Arthritis/Joint Disorder]Thyroid Disease]Dizziness]Skin Problems]Ulcer/Stomach Problems]Ear, Nose, Throat	Do any blood relatives have or have had? Is []Glaucoma []Eye Disease []Diabetes []High Blood Pressure []Heart Disease
List allergies to medications	18 mar(88 7)	TOUR STANFORM TO BE OF STANFORM STANFORM
List other allergies		tayf stuttingark at test altitudinger
Do you take medication regular dosages	ly?Please list all medi	cines(including eye drops) and
Social history questions. (We a Do you: Exercise Y or N		co Y or N
pertains. I give permission for the doc the Parent or Legal Guardian of the M	ctor(s) to examine, diagnose and inor and have the authority to an d materials rendered. If enrolled	If of the Minor for which this information initiate treatment. I further attest that I am athorize care and treatment. I am I in a health plan, I am responsible for all
Patient (Parent or Guardian-Plea	ase sign and print name)	Today's Date
Doctor's Signature Please complete Insurance Inf		Initials Review Date ner side.