Robbins Eye

PATIENT INFORMATION

Name_____Birthdate_____Age_____

Address_____City_____State_____Zip_____

Phone (H)_____(C)_____Soc. Sec # (Last 4 digits) _____

E-mail address _____ Hobbies_____

Employer/ Occupation _____ Phone (W) _____

Sex: Male Female Do you live alone? Yes No

Single Married Widowed Divorced Domestic Partner

Do you operate a motor vehicle? Yes No

Do you Smoke? Yes No (If yes, how much_____)

IN CASE OF EMERGENCY, CONTACT PERSON

Name_____Relationship_____

Phone (H)_____(W)_____(C)_____

HOW DID YOU HEAR ABOUT US? (circle all that apply)

Radio: WHAM WPXY WCMF Facebook Newspaper Yellow pages

Television: Ch 8 Ch 10 Ch 13 R News www.robbinseye.com Twitter

Friend/Relative- Name _____

Referring Physician or Eye Doctor- Name_____

Reason for referral_____

MEDICAL HEALTH HISTORY

Primary Care Physician: _____ Phone#:_____

Medical Insurance: _____Policy #:_____

Policy Holder's name:_____Date of Birth: _____

Eye Doctor's Name_____Date of last eye exam_____

How long have you worn glasses?_____

Has your prescription been changing regularly? (a change every 1-2 years) Yes No

Are you a Contact Lens Wearer? Yes No (circle all that apply) Soft Hard Gas permeable Extended Wear

Total years worn: _____ Last worn when? _____Have you ever worn contact lenses for monovision to help with near tasks? Yes No

Medications currently being taken and dosages: (list all including vitamins and over the counter medication)_____

_____

Allergies:

- Foods	□Yes □ No	- Medications	□Yes □ No (please list)_____
- Iodine	□Yes □ No	-Seasonal/Pollens	□Yes □ No
- Latex	□Yes □ No	-Skin	□Yes □ No

If yes to any of above, please explain: _____

Anxiety/Nervousness	□Yes □ No	Heart Problems	□ Yes □ No
Arthritis	□Yes □ No	Hepatitis	□ Yes □ No
Asthma	□Yes □ No	Herpes Zoster(shingles)	□ Yes □ No
Breathing Problems	□Yes □ No	Herpes Simplex (cold sores)	□ Yes □ No
Cancer (type:_____)	□Yes □ No	High Blood Pressure	□ Yes □ No
Chronic Bronchitis	□Yes □ No	High Cholesterol	□ Yes □ No
Collagen Vascular Disease	□Yes □ No	Lupus Erythematosis	□ Yes □ No
Contact Lens Wear Problems	□Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Depression	□Yes □ No	Sjogren's Syndrome	□ Yes □ No
Diabetes	□Yes □ No	Skin Problems	□ Yes □ No
Chronic Dry eyes	□ Yes □ No	TB	□ Yes □ No
Eczema/Psoriasis	□ Yes □ No	Thyroid Disease	□ Yes □ No
Family History of Keratoconus	□ Yes □ No	For women, are you?:	
Fibromyalgia/Chronic Fatigue	□ Yes □ No	Menopausal/ Postmenopausal	□ Yes □ No
Frequent Styes/ Pinkeye	□ Yes □ No	Pregnant/ Nursing	□ Yes □ No
Do you smoke?	□ Yes □ No	If yes,number of packs per day? _____	

Do you have pain in your eyes upon awakening in the morning? □ Yes □ No

Have you ever had abnormal or unusually slow healing from a skin wound or injury? □ Yes □ No

Have you ever had problems with fainting when receiving shots or when having blood drawn? □ Yes □ No

Have you had or are you considering cosmetic eyelid surgery? □ Yes □ No If Yes, when?_____

Do you use artificial tears? □ Yes □ No If Yes, name of brand and how often?

_____

Any Previous Eye Injuries? □ Yes □ No If yes, what type and when?

_____

Any Previous Eye Surgery? □ Yes □ No If yes, what type of surgery (PRK, LASIK,Cataract) and when?

_____

Have you or anyone in your family ever been diagnosed with or had**: Cataracts, Corneal Transplants, Glaucoma or Unexplained Poor Vision?** □ Yes □ No If yes, who?

_____

Any additional eye or general health information that we should be aware of:

_____

_____

RELEASE OF INFORMATION

I assign all medical/surgical benefits to Robbins Eye Associates for services performed by Robbins Eye Associates staff and authorize the release of information concerning my care to the health insurance agency. I understand and agree that, regardless of insurance status, I am ultimately responsible for the balances of my account for any professional services rendered. Furthermore, I understand that if my account is turned over for collection, I will be responsible for all fees and expenses incurred by any collection agency or attorney.

SIGNED _____ **DATE** _____

(Patient/ Guardian/ Responsible individual – must be 18 years or older to sign)