Agnone, Morrison & Associates Eye Physicians & Surgeons, Inc.

Patient Information

Name: ____ **Gender: Male**________ **Female**________
Last First Middle

Date of Birth _____/_____/______ **Social Security #**_______-_______-_______

Address: ____

Cell Phone: (______) ____-________ **E-Mail Address:** ____

Relationship Status: ☐ **Single** ☐ **Married** ☐ **In a Relationship** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Occupation (Current or previous): ____ ☐ **Retired**

Employer's Name and Phone Number: ____

Preferred Pharmacy: ____ **Address:** ________________________

How Did You Hear About Us? (If patient, list name) ____

Emergency Contact: ____________________ **Relationship:** _______________ **Phone** (___) _____-______

May we release protected health information to this individual? ☐ **Yes** ☐ **No**

Insurance Information

Policyholder Name: _____________________________________ **Social Security #**_______-_______-________

Address (If Different than Patient): ____

Phone # (____) _____-_______ **Date of Birth:** _____/_____/_______ **Employer:** ___________________________

Employer's Phone Number (____) ______-_______

Employer's Address: ____

Medical Information

Primary Medical Physician: _____________________________ **Telephone Number:** (____) ______-________

Address: ____

Previous Eye Care: ____

ALL Other Physicians Involved in Your Care: ____

Social History

Individuals living in your household:____

Alcohol Use: Y/N #/week? _________ **Caffeine Use: Y/N #/Day?** _________ **Kind?** _________ **Drug Use: Y/N**

Tobacco Use: Y/N #/Day? ___________ **How many years?** ______________ **Quit Date:** _________

Do you have any pets? If so, what kind/breed? ____

Do you travel? If so, domestically/internationally? ____

Hobbies: ____

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Patient Medical History Questionnaire

Review of Systems: Please check any of the following health problems which you have or have had:

Please notate the year in which you were diagnosed with any of these health problems.

Cardiovascular	**Respiratory**	**Hematologic/Lymphatic**	**Gastrointestinal**
___ Heart disease	___ Lung disease	___ Anemia	____ Ulcers
___ Heart attack/chest pain	___Tuberculosis	___ Bleed/bruise easily	____ Colitis/diverticulitis
___ High blood pressure	___ Sleep apnea		
___ Stroke			
___ Congestive Heart Failure	**Genitourinary**	**Musculoskeletal/Skin**	**Ear/Nose/Throat**
___ Heart valve problems	____ Kidney problems	____ Arthritis	____ Nose bleeds
___ Edema	____ Bladder problems	____ Joint Replacement	____ Ear Ringing
___ Other	____ Prostate problems	____ Joint pain/stiffness	____ Dry mouth
Neurologic/Psychiatric	**Endocrine**		
____ Seizures/convulsions	____ Thyroid disease		
____ Alzheimer's	____ Diabetes	**How long?** __________________	
____ Parkinson's disease	If you checked diabetes, are you treating with:		
____ Mental health problems	☐ diet	☐ oral medication ☐ insulin	

Any Additional Health Problems Not Listed Above:

____ ____

____ ____

Past Medical History: (Please list any surgeries, injuries, operations, or hospitalizations other than eyes)

____ ____

____ ____

____ ____

____ ____

Medications: (Please list all medications that you are currently taking with the **strength and how often**, including eye drops, over the counter meds, and nutritional supplements)

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

Allergies: (Please list any allergies to any medications or medical tests)

____ ____

____ ____

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Family History: (please indicate any diseases that run in your family and who had the disease)

Cancer: **Y/N** Who? ____________________________
Heart Disease: **Y/N** Who? ______________________
Hypertension: **Y/N** Who? _______________________
Thyroid Disease: **Y/N** Who? _____________________
Retinal Detachment: **Y/N** Who? _________________
Other Retinal Disorders: **Y/N** Who? ______________
Other Medical Problems: **Y/N** Who? ______________

Diabetes: **Y/N** Who? _______________________
Neurologic Disorder: **Y/N** Who? _____________
Arthritis: **Y/N** Who? ________________________
Macular Degeneration: **Y/N** Who? ____________
Glaucoma: **Y/N** Who? _______________________
Cataracts: **Y/N** Who? _______________________
Other Eye Disorders: **Y/N** Who? ____________

Eye History: Have you ever been diagnosed with:

___ Cataracts ___ Macular Degeneration ___ Glaucoma ___ Retinal Disorders
___ Diabetic Retinopathy ___ Corneal Problems Other Eye Problems: ______________________________

Decreased near vision	Starbursts around lights	Flashes or floaters
Decreased side vision	Foreign body sensation	Mattering of eyes
Decreased distance vision	Burning sensation	Difficulty opening eyelids
Distorted/wavy vision	Itching of eyelids	Droopy eyelids
Double vision	Tearing/Watering	Crusting of eyelids
Foggy/hazy vision	Eye redness	Irritation of eyes
Glare interfering with vision	Eye pain	Growth/lesion on eyelid
Trouble with depth perception	Eye pressure	Dry eyes
Glasses/contacts for all distances	Glasses/contacts for distance vision	
Glasses/contacts for monovision	Glasses/contacts for near vision	

Eye Injections: ____
Eye Surgery/Trauma: (List what and when)
Right eye: ____
Left eye: ____
Have you ever had laser vision correction? **Yes** **No**

Where did you get your last pair of glasses/contact lenses? ___________________ **When:** _______________

Contact Lens Wearers: Type of lens: __________How long worn? __________ Replaced how often? ________
How long do you wear them each day? _______________ **Do you wear them overnight?** ________________

Present Eye Concerns or Problems You Have

____

____

____