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

Patient Information

Name:_____ **Gender: Male**_____
Female_____
Last First Middle
Date of Birth _____/_____/_____ **Social Security #**_____-_____-_____

Address:_____

Home Phone: (_____) ____-_____ **E-Mail**

Address:_____

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

Occupation (Current or previous):_____ **Retired – if so, how long?:**_____

Employer's Name and Phone Number:

_____

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:_____

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Other Physicians Involved in Your Care:

_____

Social History

Individuals living in your household:

_____

Alcohol (Number per week): _____ Tobacco Use (Packs per day): _____ Drug Use:

_____

If heavy use, how many years? _____ If previously used, year quit?

_____

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:

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)

_____ _____
_____ _____
____ _____
_____ _____
_____ _____
____

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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)

_____ _____
_____ _____
____ ____

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

___ Cancer ___ Diabetes ___Hypertension
___ Heart Disease ___ Arthritis ___ Neurologic Disorder
___ Thyroid Disease ___ Macular Degeneration ___ Cataracts
___ Retinal Detachment ___ Glaucoma
___ Other Medical Problems ___ Other Eye Disorders

Eye History: Have <u>you</u> 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	

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☐☐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 <u>You</u> Have

_____

_____

_____