TO BE COMPLETED BY PATIENT

Date ___/___/_____

Name _____ Nickname_____
(Last) (First) (M.I.)

Local Mailing Address_____ _____ Zip_____
(Street) (City) (State)

Other Address_____ _____Zip_____
(Street) (City) (State)

Email Address_____ Preferred: ☐ email/ ☐ mail

Phone (Hm):(____)_____-_____, (Wk):(____)_____-_____, (Cell):(____)_____-_____

Preferred Phone: ☐ Home / ☐ Work / ☐ Cell (Text OK? Y__, N__), Primary Doctor: _____

Preferred Language ☐ English, ☐ Spanish, ☐ Other Ethnicity: ☐ Hispanic or Latino, ☐ Not Hispanic or Latino

Soc. Sec.# __ __ __-__ __-__ __ __ __ Birth date ___/___/_____ Male ☐ / Female ☐

Spouse Name:_____ Unmarried ☐

Spouse Birth Date___/___/_____

Other Family Members Living At Home	Age	Relationship

☐ NONE

Medications and Dosage None ☐

Ex. Aspirin 81 mg once daily

If more space is needed, please attach list ☐

ANY KNOWN MEDICATION ALLERGIES: NONE ☐

FAMILY HEALTH HISTORY

Unknown History (i.e., adopted) ☐

Does/Did Any Blood Relative Have…..?			Relationship						
			Father	Mother	Brother	Sister	Son	Daughter	
Glaucoma	Y	N	F	M	B	Sis	Son	D	
Macular Degeneration	Y	N	F	M	B	Sis	Son	D	
Other Eye Disorder	Y	N	F	M	B	Sis	Son	D	
Cancer	Y	N	F	M	B	Sis	Son	D	
Diabetes	Y	N	F	M	B	Sis	Son	D	
High Blood Pressure	Y	N	F	M	B	Sis	Son	D	
Thyroid Abnormality	Y	N	F	M	B	Sis	Son	D	
Other_____	Y	N	F	M	B	Sis	Son	D	
Other_____	Y	N	F	M	B	Sis	Son	D	
Other_____	Y	N	F	M	B	Sis	Son	D	
Other_____	Y	N	F	M	B	Sis	Son	D	

Race:

- ☐ American Indian
- ☐ Alaskan Native
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Caucasian
- ☐ Other

PLEASE CONTINUE ON BACK