# 

# 310 East Main Street

**Wytheville, VA 24382**

# Patient History

Name:

|  |  |
| --- | --- |
| Address: |  |
| Email: | Sex: M F Marital Status: |
| Telephone: | Preferred Method Contact: Call or Text (circle one) |
| Social Security Number: |  |
| Date of Birth: | Age: |
| Preferred Language: |  |
| Race: | Ethnicity: |
| Employed By: | Business Telephone: |
| Employer’s Address: |  |
| Occupation: |  |
| **If patient is a minor, parent/guardian information:** |  |
| Parent/Guardian’s Name: | Date of Birth: |
| Address: |  |
| Telephone: |  |
| **Please list ALL insurance information:** (provide copy of card)  Insurance Name: | Member ID# |
| Subscriber’s Name: | Subscriber’s Date of Birth: |
| Insurance Name: | Member ID# |
| Subscriber’s Name: | Subscriber’s Date of Birth: |
| Insurance Name: | Member ID# |
| Subscriber’s Name: | Subscriber’s Date of Birth: |

**I understand that even though I have some type of insurance coverage, I am responsible for payment of services at the time they are rendered after all insurance billing has been exhausted. To the best of my knowledge, the preceding and following information is complete and correct.**

Patient or parent/guardian signature Date

# Medical History

CIRCLE if you have been treated for or are you currently being treated for the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Anxiety |  |  | Hearing Loss |
| Arthritis |  |  | Hepatitis |
| Asthma |  |  | Hypertension (i.e. high blood pressure) |
| Atrial Fibrillation (irregular heartbeat) |  |  | HIV/AIDS |
| Bone Marrow Transplantation |  |  | Hypercholesterolemia (i.e. high cholesterol) |
| BPH (enlarged prostate) |  |  | Hyperthyroidism (e.g. Graves’ disease, etc.) |
| Breast Cancer |  |  | Hypothyroidism (e.g. Hashimoto’s, etc.) |
| Colon Cancer |  |  | Leukemia |
| COPD |  |  | Lung Cancer |
| Coronary Artery Disease |  |  | Lymphoma |
| Depression |  |  | Prostate Cancer |
| Diabetes (Type: \_\_\_\_\_) |  |  | Radiation Treatment |
| Renal Disease |  |  | Seizures |
| GERD (acid reflux)  Herpes Simplex (cold sores, etc.)  Other: |  |  | Stroke |

List any previous surgeries:

List all medications (with dosage, if known) (OR provide list)

List all medication ***allergies*** (with reaction, if known)

# Ocular History

Have you ever been told you have or have you ever been treated for any eye conditions (e.g. glaucoma, cataracts, floaters, dry eye etc.)? If so, please list:

Have you ever had any eye surgery (e.g. LASIK, injections, retinal tear, cataract removal, etc.)? If so, please list:

Do you currently use any eye drops (medicated or not)? If so, please list:

Do any of your immediate relatives have *glaucoma* or *macular degeneration* or *diabetes*? If so, please list who and what:

**Please answer the following:**

|  |  |
| --- | --- |
| Are you a current smoker? | Yes No |
|  | If no, previous smoker? \_\_\_\_\_\_\_\_\_  If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Packs per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you pregnant or nursing? | Yes No N/A |
| Do you currently wear glasses? | Yes No |
| Do you currently wear contacts? | Yes No |
|  | If no, are you interested? \_\_\_\_\_\_\_\_\_\_ |
| Who is your primary care doctor? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Location/address? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Which pharmacy do you use? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Location/address? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |