Patient History Form

Please Print Email: _____

Name: _____ Date: _____ Sex: M or F DOB: ___/___/___

Address: _____ City/State _____ Zip: _____

Home Phone: _____ Bus. Phone: _____ Cell Phone: _____

Occupation: _____ Referred by: _____ SS# ___/___/___

Family M.D.: Dr. _____ Previous Eye Doctor: _____

Last eye exam: _____ years Last Physical exam: ____ years

Health: (Circle)

Are you presently under a physicians care? Y or N If yes for what condition? _____

Do you?:

Smoke now	☐ Never	☐ Some	☐ Heavy
..in the past	☐ Never	☐ Some	☐ Heavy
Alcohol intake	☐ Never	☐ Some	☐ Heavy

Are you taking any medications?:

	☐ None

Do you have any drug allergies: Penicillin Sulfa Aspirin Codeine Other: _____

Do you have any of the following conditions? Diabetes High Blood Pressure High Cholesterol

Thyroid Cancer Epilepsy Cataracts Glaucoma Others: _____

Does any one in the family have a history of the above conditions? Y or N Please List: _____

Have you ever had any head or eye injuries? Y or N Have you ever had any eye surgery? Y or N

Do you have frequent headaches? Y or N IF YES answer the following questions:

How often? _____

Time of day? _____

Task related? Y or N

When did they start? _____

Where is the pain located? _____

Do they make you stop doing what you are doing? Y or N

Type of pain? (circle) DULL / SHARP / PIERCING / ACHING / THROBBING

Does anything help? (circle) Asprin Tylenol Sleep Other:

How long do they last? _____

Are they getting better or worse lately? BETTER WORSE SAME

NOTICE

All accounts not paid in full by the end of the billing cycle will be charged **$5.00** to cover billing and mailing.

Returned checks will be charged **$30.00**

_____

Signature

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of WILLIAM R. MARTIN, O.D.

Notice of Privacy Practices. Date _____

Patient name _____ Signature _____

(print)