NEW / UPDATED PATIENT INFORMATION
(Please Print)

Patient Name _____ Date _____

Patient Address _____City _____State _____Zip _____

Home Phone (_____)_____ Business Phone (_____)_____

Social Security Number _____ Marital Status _____

Sex _____M _____ F Age _____ Birthdate _____

Spouses Name _____ Spouses Employer _____

Emergency Contact Person _____ Phone Number (_____)_____

Nearest Relative _____Phone Number (_____)_____
(Not Living With You)

Patient Employed By _____

Business Address _____

Family Physician _____ Practice Location _____(City)

Hospital Affiliation of Your Family Physician _____

Referring Doctor_____

How Did You Learn of Our Practice? _____

Purpose of Visit _____

Who Is Responsible For This Account? _____

Relationship to Patient _____

PLEASE HAVE INSURANCE CARDS READY FOR RECEPTIONIST TO COPY-THANK YOU

AUTHORIZATION OF PAYMENT BENEFITS TO PHYSICIAN

I authorize any holder of medical or other information about me to release to my insurance carriers or intermediaries, any medical information needed for this or any other related medical claim. I request payment of authorized insurance benefits to be made to Dr. Jeffrey S. Rohr for any services rendered to me. I understand that I will be responsible for all monies due, not paid by my insurance. I understand payment for office visits is appreciated at the time service is rendered. I hereby authorize photocopies of this form to be as valid as the original.

Patient or Responsible Party Signature _____ Date _____

PATIENT HISTORY RECORD

Patient Name_____Date_____

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions? (Please provide the year diagnosed)

□ Diabetes
Diet controlled Year_____
Oral medication Year_____
Insulin Year_____

□Heart Disease
Type_____
_____
Year _____

□Arthritis
Type _____
_____
Year_____

□Cancer Type_____
Year _____

□Stroke
Year _____

□Migraine/Headaches
How often_____

□Elevated Cholesterol
Year _____

□High Blood Pressure
Year _____

□Asthma
Year_____

□Hepatitis Type_____
Year _____

□Tuberculosis
Year _____

□Thyroid Disease
Year _____

□Parkinsons
Year _____

□Alzheimers Disease
Year _____

□Mental Disease
Year _____

□HIV
Year _____

□AIDS
Year _____

□Venereal Disease
Year _____

□Other_____

2. Have you ever had any eye diseases?

□Cataracts **□Glaucoma** **□Double Vision** **□Macular Degeneration**
□Eye Infections **□Eye Trauma** **□Floaters** **□Diabetic Retinopathy**
□Eye pain **□Flashes of Light** **□Blurred Vision** **□Amblyopia (Lazy Eye)**
□Retinal Tear or Detachment **□Change in Color Vision**
□Laser Treatment, if yes please Explain_____
_____

3. Have you ever had any surgery (including eye surgery)? □ Yes □No
If Yes, please list type and year of surgery:_____
_____
_____
_____
_____

4. Have you ever been hospitalized? □Yes □No If Yes, please provide year and reason:
_____
_____
_____
_____

OFFICE USE ONLY

Patient Medication/Allergies

Patient Name:____**Date:**__________________________

Do You Have Any Drug Or Food Allergies? Yes □ No □ List below and describe reaction

1. ___________________________________ **4.** ___________________________
2. ___________________________________ **5.** __________________________
3. ___________________________________ **6.** __________________________

Please List <u>ALL</u> Medications Including Prescriptions, Eye Drops, Over The Counter, Aspirin, Herbal, Vitamins, Minerals, Dietary Nutritional Supplements and Injections (such as Insulin).

MEDICATION	DOSAGE (ie. mg,ml)	HOW OFTEN (ie. daily, twice a day)	HOW TAKEN (ie. Oral, injection)

Review of Symptoms

Do you have any of the following problems?:	**Yes**	**No**
Fever, unexplained weight loss/gain, fatigue, night sweats, chills	□	□
Ear/Nose/Throat problems (hearing loss, sinus problems, sore throat, etc.)	□	□
Heart problems (chest pain, irregular beat, fainting spells, attack, etc.)	□	□
Lung problems (shortness of breath, TB, wheezing, coughing, etc.)	□	□
Gastrointestinal problems (heartburn, stomach pain, diarrhea, vomiting, etc.)	□	□
Urinary problems (pain, discomfort, blood in urine, loss of control, etc.)	□	□
Skin problems (rashes, excessive dryness, etc.)	□	□
Musculoskeletal problems (muscle pains, joint pains, swollen joints, etc.)	□	□
Neurologic problems (numbness, weakness, headaches, paralysis, seizures, etc.)	□	□
Psychiatric problems (depression, anxiety, nerves, bipolar disorder, etc.)	□	□

If Yes to any of the above, circle symptom and please explain:_____

_____

Family and Social History

Do any medical or eye diseases run in your family? (e.g. diabetes, heart disease, stroke, glaucoma, lazy eye, cancer, macular degeneration, retinal detachment, blindness, retinal degeneration, etc.)

Yes □ No □ If Yes, please circle disease and explain:_____

_____

Do you smoke? Yes □ No □ If Yes, how much?_____Packs per day.

Do you drink alcohol? Yes □ No □ If Yes, how much?_____

If employed, how many hours per week do you work?_____

Comments:_____

_____

Patient Signature:_____ Date:_____

Doctor Signature:_____