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 ALL 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:________________________________