Name:
DOB:
Chart:
Age:
Date:

MEDICAL INFORMATION

HEIGHT______________ WEIGHT ______________

PCP ____________________________________ REFERRED BY ____________________________________

I. PAST HISTORY:

1) MEDICATION ALLERGIES (Including TYPE of Reaction):

2) MEDICAL CONDITIONS:

3) PAST SURGERIES (All Types) and HOSPITALIZATIONS:

II. PERSONAL EYE HISTORY:

- ☐ Eye injury/Trauma
- ☐ Crossed or Lazy Eye
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Problems
- ☐ Eye Pain
- ☐ Tearing/Itching/Burning
- ☐ Headaches
- ☐ Double Vision
- ☐ Contact Lenses

III. FAMILY HISTORY OF:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinal Problems
- ☐ Crossed Eyes/Lazy Eye
- ☐ Blindness
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Other ____________________

IV. PATIENT SMOKING STATUS

- ☐ Current Everyday Smoker
- ☐ Light tobacco smoker
- ☐ Never Smoker
- ☐ Former Smoker
- ☐ Heavy tobacco smoker

If you are a current smoker, what was your start date?________

How many packs do you smoke per day?________

If you are a former smoker, what was your quit date?________

Alcohol use?______________ If yes, how much?__________________

V. PREFERRED PHARMACY NAME: ______________________________ PHONE: ________________

VI. Preferred Language of Patient: ☐ English ☐ Spanish ☐ Other ____________________

Race of Patient: ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/ Other Pacific Islander ☐ White ☐ Unknown ☐ Declined to answer

Ethnicity of Patient: ☐ Hispanic Origin ☐ Non Hispanic Origin ☐ Unknown ☐ Declined to answer

I agree that Coastal Eye Associates may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Physician Signature ____________________________ Patient Signature ____________________________

Name:
DOB:
Chart:
Age:
Date:

REVIEW OF SYSTEMS:

NORMAL	SYSTEM	COMMENTS	
☐	Constitutional	Fever Weight Loss/Gain Other ____________________	
☐	Ear/Nose/Throat	Pain Mass/Discharge Loss of Hearing/Smell Other ____________________	
☐	Cardiovascular	Chest Pain/Angina Congestive Heart Failure MI/Bypass/Angioplasty Arrhythmia/Blockages Hypertension - Stable: YES OR NO	Last BP ______________
☐	Respiratory	Asthma Emphysema Cough Other ____________________	Use of Oxygen at Home ___YES Sleep Apnea: CPAP YES or NO
☐	Gastrointestinal	Digestive Problems Pain/Ulcers Other ____________________	
☐	Genitourinary	Frequent Urination Burning Urination	
☐	Hematologic - Lymphatic	Anemia Blood Disorder Swollen Lymph Nodes Other ____________________	Hepatitis A___ B___ C___ HIV + ___YES
☐	Musculoskeletal	Weakness Joint Pain/Arthritis Other ____________________	
☐	Skin - Integumentary	Masses-Tumors Lesions/Rashes Other ____________________	
☐	Neurologic	Weakness/Tingling/Numbness Stroke/Brain Injury Other ____________________	
☐	Psychiatric	Depression Other ____________________	
☐	Endocrine	Thyroid Graves Disease Diabetes: How Many Years? ________ Stable: YES or NO Last BS_______	
☐	Autoimmune	Lupus Rheumatoid Arthritis Cancer	