DOBBS EYE CLINIC

Today's Date

Please also complete backside of form

Patient's Information

Last Name | First | "Goes by" | Suffix

Birth Date | Age | SSN | Gender: Male Female

Mailing Address | Marital Status: Single Married Divorced Separated Widowed

City

State | Zip

Any Special Needs? Please Explain.

Preferred Contact Method: ☐ Home ☐ Work ☐ Cell ☐ Email

Home # | Work #

Cell #

Healthcare Reform - Gov'mt Requested Information

Race*

- ☐ American Indian/Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Hawaiian/Pacific Islander
- ☐ White/Caucasian

*(only mark one with largest %)

Ethnicity

- ☐ Not Hispanic/Latino
- ☐ Hispanic/Latino

Please provide email so we can send results from today's visit.

Email

Primary Language if other than English: _____

	Doctor's Name	***Doctor's City Location***
Primary Dr		
Specialist		

Pharmacy Name/Location

Account Responsible Information *(an Adult - typically for a Minor, this will be a Parent)*

Last Name | First

Birth Date | SSN

Please complete backside of form

======>

Relationship to the patient (circle) Spouse Mother Father Grandparent Guardian Other:

Patient's Eye History

		Provide Details
Glasses	YES / NO	Contacts YES / NO
Glaucoma	Y / N	
Cataracts	Y / N	
Macular Degeneration	Y / N	
Eye Injury	Y / N	
Retinal Disease	Y / N	
Blindness	Y / N	
Eye Turns In/Out	Y / N	
Lazy Eye (Amblyopia)	Y / N	
Dry Eyes	Y / N	
Diabetes	Y / N	Type 1 Type 2

OTHER: _____

Primary reason for today's visit: _____

Are you experiencing any of the following EYE problems? If Yes, please explain.

Headaches	Y / N	
Loss or blurred vision	Y / N	
Loss of side vision / double vision	Y / N	
Itching, burning, or discharge	Y / N	
Redness	Y / N	
Gritty feeling, dryness or tearing	Y / N	
Glare/light sensitivity or halos	Y / N	
Eye pain or soreness	Y / N	
Infection of eye lashes or lids, styes	Y / N	
Crusting in/around eyelashes	Y / N	
Other - explain	Y / N	

Patient's Medical History

Please circle - List others as needed.

						Please explain current treatment for condition
Constitution:	Fever	Weight Loss	Weight Gain			
Cardiovascular:	Bypass/Stint	High BP	Congestive Heart Failure			
Ears/Nose/Mouth/Throat:	Sinusitis	Hearing Loss	Dry Mouth			
Respiratory:	Asthma	Emphysema	COPD	Tuberculosis		
Gastrointestinal:	Collitis	Ulcer	Chron's	Hepatitis		
Genitourinary:	Kidney	Prostate	Urinary			
Musculoskeletal:	Arthritis	Fibromyalgia	Muscular Dystrophy			
Integumentary:	Dermatitis	Rosacea	Skin Cancer			
Neurological:	Migraines	Bell's Palsy	MS	Stroke	Seizures	
Psychiatric:	Bipolar	Dementia	Depressed			
Endocrine:	Type 2 Diabetes	Type 1 DM	Borderline DM	Thyroid		
Hematologic/Lymphatic:	Anemia	Blood Disorder	High Cholestrol	Leukemia		
Allergic/Immunologic:	Allergies	Lupus	HIV	Immune Disorder	Rheumatoid Arthritis	

Other Medical Issues: _____

Patient's Surgical History

	Describe - Provide Details	Date
Eye Surgery		
Other Surgery		

Patient's Medication List

(We can copy your med list if you have it)

Drug Name	Dosage
	-
	-

Drug ALLERGIES _____

Other ALLERGIES _____

Patient's Social History

		Please circle		
Caffeine	Never	Occasionally	Frequently	
Alcohol	Never	Occasionally	Frequently	
Exercise	Never	Occasionally	Frequently	
Marijuana/Cannabis	Never	Occasionally	Frequently	
Smoker	Never	Former	Some days	Everyday

Family Medical History

	Mom	Dad	Sibling	Child	Grand Ma	Grand Pa
Glaucoma						
Cataracts						
Macular Degeneration						
Retinal Disease						
Blindness/Vision Loss						
Lazy eye (Amblyopia)						
Diabetes						
Heart Disease						
High BP/Hypertension						
Cholesterol						
Stroke						

Other Medical Issues _____

<== **Please indicate Tobacco Status**