621 Pound Hill Road
Suite 104
North Smithfield, RI 02896
(401) 769-6323

Patient History

Name:

Address:

Email: Sex: M F Marital Status:

Telephone:

Social Security Number:

Date of Birth: Age:

Preferred Language:

Race: Ethnicity:

Employed By: Business Telephone:

Employer's Address:

Occupation:

Spouse's Name: Employed By:

Business Telephone: Occupation:

Employer's Address:

If patient is a minor, please provide parental/guardian contact information:

Parent/Guardian's Name: Date of Birth:

Address:

Telephone: Social Security Number

Please list ALL insurance information

Insurance Name: Member ID#

Subscriber's Name: Subscriber's Date of Birth:

Insurance Name: Member ID#

Subscriber's Name: Subscriber's Date of Birth:

Insurance Name: Member ID#

Subscriber's Name: Subscriber's Date of Birth:

I understand that even though I have some type of insurance coverage, I am responsible for payment of services at the time they are rendered after all insurance billing has been exhausted. To the best of my knowledge, the preceding and following information is complete and correct.

Patient or parent/guardian signature Date

Medical History

CIRCLE if you have been treated for or are you currently being treated for the following:

Anxiety	Hearing Loss
Arthritis	Hepatitis
Asthma	Hypertension (i.e. high blood pressure)
Atrial Fibrillation (irregular heartbeat)	HIV/AIDS
Bone Marrow Transplantation	Hypercholesterolemia (i.e. high cholesterol)
BPH (enlarged prostate)	Hyperthyroidism (e.g. Graves' disease, etc.)
Breast Cancer	Hypothyroidism (e.g. Hashimoto's, etc.)
Colon Cancer	Leukemia
COPD	Lung Cancer
Coronary Artery Disease	Lymphoma
Depression	Prostate Cancer
Diabetes	Radiation Treatment
Renal Disease	Seizures
GERD (acid reflux)	Stroke
Herpes Simplex (cold sores, etc.)	
Other:	

List any previous surgeries: ____________________

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List all medications (with dosage, if known)

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List all medication ***allergies*** (with reaction, if known)

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Ocular History

Have you ever been told you have or have you ever been treated for any eye conditions (e.g. glaucoma, cataracts, floaters, dry eye etc.)? If so, please list:

____

____

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Have you ever had any eye surgery (e.g. LASIK, injections, retinal tear, cataract removal, etc.)? If so, please list:

____

____

____

Do you currently use any eye drops (medicated or not)? If so, please list:

____

____

Do any of your immediate relatives have *glaucoma* or *macula degeneration* or *diabetes*? If so, please list who and what:

____

Please answer the following:

Are you a current smoker? Yes No
If no, previous smoker? __________
If yes, how long? ________________
Packs per day ________________

Are you pregnant or nursing? Yes No

Do you currently wear glasses? Yes No

Do you currently wear contacts? Yes No

If no, are you interested? ___________

Who is your primary care doctor? ___________________________________
Location/address? ___________________________________
____

Which pharmacy do you use? ___________________________________
Location/address? ___________________________________
____