NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME#:_____ CELL#:_____ WORK#_____

EMAIL
ADDRESS:_____

SS#_____ SEX: MALE / FEMALE MARITAL STATUS: S / M / W / D

REFERRED TO OFFICE BY: ☐ WEBSITE ☐ INTERNET ☐ FAMILY/FRIEND ☐ MAILER

☐ HEALTH FAIR ☐ TV ☐ INSURANCE CO. ☐ OTHER_____

EMERGENCY CONTACT INFORMATION

NAME:_____ RELATION TO PATIENT:_____

ADDRESS: _____ DATE OF BIRTH:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME#:_____ CELL#:_____ WORK#_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payments to Akler Eye Center for services rendered under their supervision. I understand that I am financially responsible for any balance unpaid or not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Akler Eye Center to release any medical or incidental information that may be required for either medical care or in the processing application for financial benefit.

MEDICARE

I certify that the information given by me is correct. I authorize release of all medical records on request. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original.

_____ _____

Patient Signature Date

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Nickname: _____ Date of Birth: ____/____/_____

Primary Care Physician: _____ Referring /Specialty Dr. _____

Pharmacy: _____ Location(street & city) _____

Race: ◻ American Indian or Alaska Native ◻ Asian ◻ Black or African American

◻ Native Hawaiian or Other Pacific Islander ◻ White

Allergies: Reaction Severity

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

◻ Overall Healthy
◻ Amblyopia (Lazy eye)
◻ Aphakia
◻ Astigmatism
◻ Cataracts
◻ Diabetic Retinopathy
◻ Dry Eyes
◻ Glaucoma
◻ Hyperopia (Far sighted)
◻ Iritis
◻ Keratoconus
◻ Macular Degeneration
◻ Myopia (Near sighted)
◻ Optic Neuritis
◻ Retinal Detachment

Other_____

Ocular Surgeries: (Please mark all that apply)

◻ No prior ocular surgery
◻ Blepharoplasty
◻ Cataract Surgery
◻ Corneal Transplant
◻ Foreign Body Removal
◻ Retinal Laser Surgery
◻ LASIK
◻ PRK / Epi-LASIK
◻ Punctal Plugs
◻ RK
◻ Strabismus Surgery
◻ Trabeculectomy
◻ Vitrectomy

Other_____

Ocular Significant Illnesses: (Please mark all that apply)

◻ Overall Healthy
◻ AIDS
◻ Diabetes
◻ Rheumatoid Arthritis
◻ Herpes
◻ HIV Positive
◻ Hypertension
◻ Hypothyroidism
◻ Lupus
◻ Multiple Sclerosis
◻ Sjogrens
◻ Graves Disease
◻ Hyperthyroidism

Other_____

Current Eye Medications: (Please list)

_____

_____

_____

Systemic Illnesses:

◻ No history of illnesses
◻ Anemia
◻ Arthritis
◻ Arrhythmia
◻ Asthma
◻ Bleeding Disorder
◻ Cancer
◻ Thyroid Disease
◻ Congestive Heart Failure
◻ COPD
◻ Diabetes
◻ Eczema
◻ Fibromyalgia
◻ Headache
◻ Hearing Loss
◻ Hepatitis
◻ High Blood Pressure
◻ High Cholesterol
◻ HIV
◻ Kidney Disease
◻ Kidney Stones
◻ Liver Disease
◻ Lung Disease
◻ Lupus
◻ Migraine
◻ Polymyalgia
◻ Psychiatric Disorder
◻ Skin Cancer
◻ Stroke

Other_____

General Surgeries / Operations: (Please list)

_____

_____

_____

Please continue on the back side of this page →

Current Other Medications: (Please list)

_____

_____

_____

Infections: (Please mark all that apply)

- ◻ Overall Healthy
- ◻ Chicken Pox
- ◻ Hepatitis A / B / C
- ◻ Herpes Simplex
- ◻ Herpes Zoster / Shingles
- ◻ Histoplasmosis
- ◻ HIV / AIDS
- ◻ Meningitis
- ◻ MRSA
- ◻ Syphillis
- ◻ Toxoplasmosis
- ◻ Wound Infection

Other_____

Family History:

- ◻ Arthritis
- ◻ Blindness
- ◻ Cancer
- ◻ Cataracts
- ◻ Diabetes
- ◻ Glaucoma
- ◻ Heart Disease
- ◻ High Blood Pressure
- ◻ Kidney Disease
- ◻ Lazy Eye
- ◻ Macular Degeneration
- ◻ Retinal Disease
- ◻ Stroke
- ◻ TB

Other_____

Social History: (Please mark all that apply)

Smoking: ◻ current every day smoker ◻ current some day smoker ◻ former smoker ◻ never smoked

Alcohol Use: ◻ Yes ◻ No If yes how much and how often?_____

Drug Use: ◻ Yes ◻ No If yes what and how often?_____

Review of Systems: (Please mark all that apply)

Eyes
- ◻ Previous Surgery
- ◻ Contact Lens
- ◻ Pain
- ◻ Double Vision
- ◻ Glaucoma
- ◻ Cataracts
- ◻ Macular Degeneration
- ◻ Dry Eyes
- ◻ Flashes
- ◻ Floaters

Ear, Nose, and Throat
- ◻ Hard of Hearing
- ◻ Ringing in Ears
- ◻ Vertigo

Cardiovascular
- ◻ Chest Pain
- ◻ Dizziness
- ◻ Fainting Spells
- ◻ Shortness of Breath
- ◻ Irregular Heart Beat
- ◻ Difficulty Lying Flat

Constitutional
- ◻ Fatigue / Weakness
- ◻ Fever
- ◻ Weight Gain / Loss

Respiratory
- ◻ Cough
- ◻ Congestion
- ◻ Wheezing
- ◻ Asthma

Gastrointestinal
- ◻ Heartburn
- ◻ Nausea / Vomiting
- ◻ Jaundice / Hepatitus

Genito-Urinary
- ◻ Pain / Difficulty
- ◻ Blood in Urine
- ◻ History of Kidney Stones
- ◻ History of STD's

Psychiatric
- ◻ Anxiety / Depression
- ◻ Mood Swings
- ◻ Difficulty Sleeping

Endocrine
- ◻ Increased Thirst
- ◻ Increased Hunger
- ◻ Increased Urination
- ◻ Increased Sweating
- ◻ Fingernail Changes

Blood / Lymphnodes
- ◻ Easy Bruising
- ◻ Gums Bleed Easy
- ◻ Prolonged Bleeding
- ◻ Heavy Aspirin Use

Musculo/Skeletal
- ◻ Stiffness
- ◻ Arthritis
- ◻ Joint Pain / Swelling

Skin
- ◻ Rash / Sores
- ◻ Lesions
- ◻ Hives / Eczema

Neurological
- ◻ Seizures
- ◻ Weakness / Paralysis
- ◻ Numbness
- ◻ Tremors

Immunologic
- ◻ Hives
- ◻ Itching
- ◻ Runny Nose
- ◻ Sinus Pressure