2020 Ophthalmic Consultants

1000 South Eliseo Drive, Suite 203

Greenbrae, California 94904

Patient Name _____

Date of Birth ____/____/____ Sex ___ Recent Weight _____ Recent Height _____

Address _____ City _____ State _____ Zip _____

Home phone # _____ Cell phone # _____

Work phone # _____

Email address (for appointment reminders/a relative's email if you do not have one since you will be reminded of all appointments by email) _____

Social Security Number _____ Driver's License Number _____

Employer _____ Occupation _____

Work Address _____

Name of person to notify in an emergency _____

Phone # _____ Relationship to patient_____

Referring Physician _____ Primary Care Physician _____

Preferred Pharmacy _____

Ethnicity _____ Preferred Language ☐ English ☐ Other _____

I understand that my privacy is protected and I have received a copy of the Private Policy ☐ YES

I understand that I am financially responsible for all of the charges whether or not paid for by the insurance. I am fully responsible to understand my insurance coverage. If I am unsure of coverage, I am responsible to contact my insurance company directly before I seen by the doctor. I understand any visit, refraction, contact fitting or contacts, cosmetic procedures, cancellation fees, emergency

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fees, telephone fees, medical record fees not covered by insurance will be payable at the time of visit. I hereby authorize the doctor to release all information necessary to secure the payment of benefits not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of the benefits.

Signed: _____ Date: _____

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Reason for today's visit?

_____

Personal Medical History: Please list past and current medical problems.

_____ _____ _____

_____ _____ _____

Surgical History: Please list surgeries you have had and the approximate year.

_____ _____ _____

_____ _____ _____

Family Medical History: Please list any significant medical conditions affecting family members. (glaucoma, cataracts, macular degeneration, lazy eye,blindness, diabetes, high blood pressure)

_____ _____ _____

_____ _____ _____

Drug Allergies: Please list any medication you have had a reaction to.

Name of Medicine	Reaction	Name of Medicine	Reaction

Medication List:

Name	Dose	Frequency	Name	Dose	Frequency

Do you smoke? ☐ Yes ☐ No If yes: packs per day? _____ Number of Years _____
If no, did you smoke in the past? ☐ Yes ☐ No If yes: packs per day? ____ Number of Years _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks do you have per week? _____

Do you take drugs? ☐ Yes ☐ No If yes, what and how often? _____

How much caffeine do you have each day? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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Have you had your flu shot? ▢ Yes ▢ No

REVIEW OF SYMPTOMS:

General: weight change, change in strength or exercise tolerance ▢ Yes ▢ No

Head: headaches, vertigo, injury. ▢ Yes ▢ No

Eyes: vision, diplopia, pain. ▢ Yes ▢ No

Breast: noted lumps, tenderness, swelling, nipple discharge. ▢ Yes ▢ No

Chest: dyspnea, wheezing, hemoptysis, cough. ▢ Yes ▢ No

Heart: chest pains, palpitations, syncope, orthopnea. ▢ Yes ▢ No

Abdomen: change in appetite, dysphagia, abdominal pains, bowel habit changes, emesis, melena. ▢ Yes ▢ No

Genitourinary: urinary urgency, dysuria, change in nature of urine. ▢ Yes ▢ No

Gynecology: change in menses, dysmenorrhea, vaginal discharge, pelvic pain.▢ Yes ▢ No ▢ N/A

Musculoskeletal: pain in muscles or joints, limitation of range of motion, paresthesias or numbness. ▢ Yes ▢ No

Neurologic: weakness, tremor, seizures, changes in mentation, ataxia. ▢ Yes ▢ No

Psychiatric: depressive symptoms, changes in sleep habits, changes in thought content▢ Yes ▢ No

Other:

_____

Are you interested in a Lasik consultation? ▢ Yes ▢ No
Are you interested in skin rejuvenation consultation? __Yes __No