548 W 3rd
Jamestown, NY 14701
(716) 488-1147
FAX 716-790-8126

Patient Name: _____ Birth Date: _____ Age:_____Male ___ Female ___

Primary Language: _____ Race: _____Ethnicity:_____Hispanic ____ Non-Hispanic

Street _____ Town _____ State _____ Zip _____ SocSec# _____

Primary Phone _____ Secondary # _____Work # _____

Pharmacy _____ Emergency Contact _____ Phone # _____

Primary Care Physician: _____ Phone # _____

Address _____State____ Zip _____

We must have your insurance card so we can scan it into your chart. Medicaid, Family Health Plus, Child Health Plus, Community Card must be presented bore an examination will be given.

Current Medications: please include name, strength and how often you take it. Aspirin, vitamins & herbal medications are considered medications.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies to Medications or Anesthesia:

_____ _____ _____

SOCIAL HISTORY:

Tobacco Use: ❑ Yes ❑ No If yes, what product and how much? _____

Alcohol Use: ❑ Yes ❑ No If yes, beverage, quantity, frequency? _____

Lives: ❑ Alone ❑ With Spouse ❑ With family ❑ With friend

FAMILY HISTORY:

❑ Arthritis ❑ Emphysema ❑ High Blood Pressure ❑ Cancer ❑ Epilepsy ❑ Stroke ❑ Diabetes ❑ Heart

❑ Tuberculosis ❑ Glaucoma ❑ Cataracts ❑ Retinal Disease ❑ Macular Degeneration

MEDICAL HISTORY:

- ❑ Allergies
- ❑ Anemia
- ❑ Any Drug Habit
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Back Ache/Problem
- ❑ Bipolar Disorder
- ❑ Bladder Disease
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Cholesterol
- ❑ Chronic Cough
- ❑ Diabetes
- ❑ Difficulty Hearing
- ❑ Diverticulitis
- ❑ Easy Bruising
- ❑ Epilepsy
- ❑ Gallbladder Disease
- ❑ Gonorrhea/Syphilis
- ❑ Hay Fever
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Low Blood Sugar
- ❑ Jaundice
- ❑ Joint Swelling
- ❑ Kidney Disease
- ❑ Meningitis
- ❑ Obstructive Sleep Apnea
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Tuberculosis
- ❑ Other

_____
_____
_____

SURGICAL HISTORY: Please list the surgeries you have had.

_____ _____ _____
_____ _____ _____

OCULAR HISTORY:

❑ Cataracts ❑ Glaucoma ❑ Macular Degeneration ❑ Retinal Disease
❑ Retinal Detachment ❑ Diabetic Retinopathy ❑ Dry Eye ❑ Corneal Disease ❑ Corneal Abrasion
❑ Foreign Body - Injury _____

OCULAR SURGERY/LASER:

Cataract: ❑ Right Eye ❑ Left Eye
Glaucoma: ❑ Right Eye ❑ Left Eye
Retinal Detachment Repair: ❑ Right Eye ❑ Left Eye
Tear Duct Probing: ❑ Right Eye ❑ Left Eye
Lid Surgery: ❑ Right Eye ❑ Left Eye

Laser: ❑ Right Eye ❑ Left Eye - For: _____
Lasik: ❑ Right Eye ❑ Left Eye

REVIEW OF SYSTEMS: Please circle any of the following symptoms that you are CURRENTLY having. You may also give further explanation if you wish.

Constitution: fever, unexpected weight loss or gain, fatigue _____
Ears/Nose/Throat: hearing loss, sinus, sore throat, nose bleeds _____
Cardiovascular: chest pain, irregular heartbeat, palpitations _____
Respiratory: shortness of breath, wheezing, cough _____
Gastrointestinal: heart burn, abdominal pain, diarrhea, vomiting
Change in bowel habits, blood in stool _____
Urinary: pain or discomfort, blood in urine, change in frequency _____
Integumentary: skin rash, excessive skin dryness, itchy _____
Musculoskeletal: muscle aches, joint pain, swollen joints _____
Neurologic: numbness, tingling, weakness, headaches, paralysis _____
Psychiatric: depression, anxiety _____
Endocrine: thirst, intolerance to hot, intolerance to cold _____
Hema/Lymph: easy bruising, easy bleeding, anemia _____