PT # _____

ALLEN C. RICHMOND MD PC.

WELCOME TO OUR PRACTICE

PLEASE COMPLETE THE INFORMATION BELOW
BE ASSURED OF THE PRIVACY OF ALL INFORMATION GIVEN
IT IS FOR OFFICE USE ONLY

PATIENT NAME: Mr. Mrs. Miss Ms. Dr. Rev. MARITAL STATUS: _____

Last_____ First_____ MI_____ Suffix _____

Address: _____

City_____ State_____ Zip_____

Email Address _____

Phone: Home ( ) _____ Cell ( ) _____ Work ( ) _____

Date of Birth: _____ SS# _____ Family Physician _____

Occupation _____ Employer _____

Responsible Party if other than above:

Name _____ Relationship _____ Date of Birth: _____

SS# _____ Address_____

Phone: Home ( ) _____ Cell ( ) _____ Work ( ) _____

Emergency contact: Name _____ Phone _____

THANK YOU FOR CHOOSING OUR PRACTICE
PLEASE TELL US HOW YOU SELECTED OUR PRACTICE

Recommended by: Please check as appropriate.

Friend _____	Hospital ____	Yellow Pages _____	Optometrist _____
Relative ____	School _____	Advertisement _____	Provider Directory ____
Doctor _____	Insurance____	Web Site _____	Other _____

If you checked physician, relative, friend or other, please specify below:

_____

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of **Birth** _____ Date of **last eye exam** _____

List any **medications** you currently take (Rx and over-the-counter): _____

_____

Do you have **allergies** to any medications? **YES NO**
If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? **YES NO UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**
Have you ever had a blood transfusion?..... **YES NO**
Do you drink alcohol?..... **YES NO** If YES, how much? _____
Do you smoke?..... **YES NO** If YES, how much? _____ How many years? _____

Physician's Signature _____ *Date* _____