

Mr. Mrs. Ms. Date _____

Name _____ Birth Date ____ / ____ / ____

Social Security Number _____

Medicare Number & Letter (if applicable) _____

Home Address _____ City _____ Zip _____

Home Phone Number (_____) _____ Work Phone Number (_____) _____

Employed by _____

Hobbies or occupational requirements _____

Spouse's Name _____ Referred by _____

Who is responsible for paying for services? _____

In case of emergency, who can we contact? _____ Phone (_____) _____

Briefly state any visual problems _____

Last Medical Exam ____ / ____ / ____ Last Eye Exam ____ / ____ / ____

Name of Medical Doctor _____ Dr.'s Phone _____

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I understand that I am responsible to pay for the services rendered, including reasonable attorney's fees and costs of collection in the event of default.

I authorize payment of medical benefits to Dr. Rubin for services rendered.

Signature _____ Date _____

Medical History

Do you have allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): None

List all major injuries, surgeries and/or hospitalizations you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping lid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____

Do you wear contacts? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? no yes

Family History

Please note any family history (parents, grandparents, siblings and/or children, living or deceased) for the following medical conditions.

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU	DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Review of Systems

Do you currently, or have you ever had any problems in the following area? (If YES, please explain & list medications.)

	NO	YES	?	EXPLAIN/LIST MEDICATIONS		NO	YES	?	EXPLAIN/LIST MEDICATIONS
CONSTITUTIONAL					Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
(fever, weight loss/gain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INTEGUMENTARY (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
NEUROLOGICAL					Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	RESPIRATORY				
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EYES					Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	VASCULAR/CARDIOVASCULAR				
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	GASTROINTESTINAL				
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	GENITOURINARY				
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	(genitals/kidney/bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	BONES/JOINTS/MUSCLES				
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Infection of					LYMPHATIC/HEMATOLOGIC				
Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	ENDOCRINE (thyroid/other glands)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EARS, NOSE, MOUTH, THROAT					PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____					

Social History

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If yes, please describe: _____

Do you use tobacco products? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you use illegal drugs? no yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: no yes Gonorrhea Syphilis HIV Hepatitis