Patient Information Form

Patient Name: _____Date of Birth: _____ Age: ___
Parent or Guardian (if under 18): _____
Home Address (no P.O. Boxes): _____
Mailing Address (if different from above): _____
Home Phone: _____ Cell Phone: _____
email: _____ Work Phone: _____
would you prefer to receive appointment reminders via email? ____ yes ____ no
social security #: _____ Driver's License #: _____
Who referred you? _____ Primary Care Physician: _____

Insurance Carrier: _____ Certificate No: _____
(name and address) _____ Policy or Group No: _____
Insurance Carrier: _____ Certificate No: _____
(name and address) _____ Policy or Group No: _____
Medicare No: _____

Demographics:

- Preferred language: ☐English ☐other _____
- Gender: ☐Male ☐Female
- Race: ☐White ☐Native American ☐Asian ☐Black or African American ☐Pacific Islander ☐Other _____ ☐Prefer not to answer
- Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Prefer not to answer

Preferred pharmacy: _____ Phone: _____
Address: _____

Medical History

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation (Irregular Heartbeat)
☐ BPH
☐ Bone Marrow Transplantation
☐ Breast Cancer
☐ Colon Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End Stage Renal Disease
☐ GERD
☐ Hearing Loss
☐ Hepatitis
☐ Hypertension
☐ HIV / AIDS
☐ Hypercholesterolemia
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke

☐ Other _____
☐ None

Past Surgeries:

_____

_____ ☐ **None**

Ocular History

Cataract: ☐ Right eye, ☐ Left eye

Glaucoma: ☐ Right eye, ☐ Left eye

Macular Degeneration: ☐ Right eye, ☐ Left eye

☐ glasses ☐ contact lenses

☐ Other: _____

Ocular Surgery

Cataract surgery: ☐ Right eye, ☐ Left eye

LASIK: ☐ Right eye, ☐ Left eye

Eyelid/Eye socket surgery: ☐ Right eye, ☐ Left

☐ other: _____

Family History (*please specify relative*)

☐ Blindness ☐mother, ☐father, ☐brother, ☐sister, ☐other_____

☐ Cancer ☐mother, ☐father, ☐brother, ☐sister, ☐other_____

☐ Cataracts ☐mother, ☐father, ☐brother, ☐sister, ☐other_____

☐ CVA (stroke) ☐mother, ☐father, ☐brother, ☐sister, ☐other_____

☐ Diabetes ☐mother, ☐father, ☐brother, ☐sister, ☐other_____

☐ Glaucoma ☐mother, ☐father, ☐brother, ☐sister, ☐other_____

☐ Heart Disease ☐mother, ☐father, ☐brother, ☐sister, ☐other

☐ Hypertension (high blood pressure) ☐mother, ☐father, ☐brother, ☐sister, ☐other_____

☐ Macular Degeneration ☐mother, ☐father, ☐brother, ☐sister, ☐other_____

☐ Migraine ☐mother, ☐father, ☐brother, ☐sister, ☐other_____

☐ Retinal Detachment ☐mother, ☐father, ☐brother, ☐sister, ☐other_____

☐ Strabismus ☐mother, ☐father, ☐brother, ☐sister, ☐other_____

☐ Other_____☐mother, ☐father, ☐brother, ☐sister, ☐other_____

☐ **None**

Medications: _____

_____

_____

_____

☐ **None**

Allergies (specify reaction): _____

☐ No known drug allergies

Social History

Do you drink alcohol? ☐yes ☐no how many drinks per day? _____

Occupation: _____

Smoking history (please choose one):

☐ current every day smoker

☐ current some day smoker

☐ former smoker

☐ never smoker

If you have ever smoked:

how many packs per day? _____

for how many years? _____

Other drug use: _____

Current Eye Problem (what brings you here today?): _____
_____

Review of Systems (do you have any of the following),
PLEASE ANSWER ALL QUESTIONS:

poor vision	☐ yes ☐ no	joint pain	☐ yes ☐ no
eye pain	☐ yes ☐ no	stiffness	☐ yes ☐ no
tearing	☐ yes ☐ no	arthritis	☐ yes ☐ no
eye redness	☐ yes ☐ no	rash	☐ yes ☐ no
fever or chills	☐ yes ☐ no	changing moles	☐ yes ☐ no
weight loss	☐ yes ☐ no	headache	☐ yes ☐ no
stuffy nose	☐ yes ☐ no	seizure	☐ yes ☐ no
ear ache	☐ yes ☐ no	stroke	☐ yes ☐ no
cough	☐ yes ☐ no	paralysis	☐ yes ☐ no
dry mouth	☐ yes ☐ no	anxiety	☐ yes ☐ no
high blood pressure	☐ yes ☐ no	depression	☐ yes ☐ no
rapid heart beat	☐ yes ☐ no	diabetes	☐ yes ☐ no
wheezing	☐ yes ☐ no	thyroid abnormalities	☐ yes ☐ no
shortness of breath	☐ yes ☐ no	bleeding	☐ yes ☐ no
upset stomach	☐ yes ☐ no	anemia	☐ yes ☐ no
diarrhea	☐ yes ☐ no	allergies	☐ yes ☐ no
constipation	☐ yes ☐ no	hay fever	☐ yes ☐ no
burning on urination	☐ yes ☐ no	hives	☐ yes ☐ no
urinary frequency	☐ yes ☐ no		

Notice of Privacy Practices

I acknowledge that I was provided with a copy of Dr. Savar's Notice of Privacy Practices.

Patient Signature: _____ Date: _____

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