GENERAL HISTORY

RESPONSIBLE PARTY: _____ DATE _____

PATIENT INFORMATION: NAME: _____ SS# _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

E-MAIL ADDRESS: _____

OCCUPATION: _____ EMPLOYED BY: _____

DATE OF BIRTH: _____ AGE: _____ REFERRED BY: _____

FAMILY PHYSICIAN: _____ AGE OF PRESENT GLASSES: _____

LAST EYE EXAM DATE: _____ FROM DR.: _____

WHAT BRINGS YOU TO OUR OFFICE TODAY? _____

HAVE YOU EVER BEEN TO SEE DR. GUBANY / DR. PASIERB IN THIS OFFICE BEFORE? _____

ARE YOU ALLERGIC TO ANYTHING? _____

DO YOU OR ANY BLOOD RELATIVES HAVE LAZY EYE? _____ WHO? _____

DO YOU HAVE FREQUENT HEADACHES? _____

WHEN, WHERE, HOW OFTEN? _____

DOES SUNLIGHT OR BRIGHT LIGHTS BOTHER YOU? _____

DO YOU EVER SEE DOUBLE? _____ WHEN? _____

DO YOU HAVE TROUBLE WITH NIGHT VISION? _____

HAVE YOU EVER HAD ANY EYE INFECTION, SURGERY OR INJURY? _____

DO YOU HAVE COLOR VISION PROBLEMS? _____

HAVE YOU EVER WORN CONTACT LENSES? _____ DO YOU NOW WEAR CONTACT LENSES? _____

HOW LONG HAVE YOU HAD THEM? _____ ARE THEY COMFORTABLE? _____

HAVE YOU WORN THEM BEFORE AND QUIT? _____ WHY? _____

ARE THEY COMFORTABLE ALL DAY? _____ HOURS WORN BEFORE DISCOMFORT BEGINS? _____

TYPE OF LENSES WORN _____ CONTACTS FIT BY DR. _____

DO YOU USE LUBRICATING EYE DROPS? _____ WHAT BRAND? _____

GENERAL HISTORY

HAVE YOU OR A BLOOD RELATIVE EVER HAD (CIRCLE):

DRY EYE SYNDROME (K. SICCA) BLEPHARITIS GLAUCOMA TUBERCULOSUS LUPUS

GOUT CATARACTS ARTHRITIS DIABETES THYROID DISORDER HEART DISEASE

HIGH BLOOD PRESSURE SJOGRENS SYNDROME SYSTEMIC SCLEROSIS TRACHOMA

POLY MYOSITIS PRIMARY BILARY CIRRHOSIS BELL'S PALSY

JUVENILE RHUMATOID ARTHRITIS STEVEN'S JOHNSON SYNDROME

HYPOVITAMINOSIS A (XEROPHTHALMIA) IRRADIATION EYE DAMAGE

CICATRICIAL OCULAR PEMPHIGOID CHEMICAL BURNS TO THE EYE

ELEVATED CHOLESTEROL MACULAR DEGENERATION

DO YOU OR ANY BLOOD RELATIVE HAVE ANY OTHER EYE DISEASE THE DOCTOR SHOULD KNOW ABOUT?

_____

_____

_____

DO YOU TAKE ANY OF THE FOLLOWING MEDICATIONS?

DECONGESTANTS ANTIHISTAMAINES DIURETICS HEART DISEASE MEDICATIONS

ULCER PRESCRIPTIONS ANTIDEPRESSANTS ANESTHETICS BETA BLOCKERS

HORMONE SUPPLEMENTS BIRTH CONTROL HI-DOSE VITAMINS

ASPIRIN REGULARLY ACNE MEDICATION

PLEASE LIST ALL MEDICATIONS BOTH OVER THE COUNTER AND PRESCRIPTION THAT YOU ARE CURRENTLY USING AND THE AILMENT THAT IT IS TREATING

_____

_____

_____

DO YOU CURRENTLY USE DRUGS, TOBACCO OR ALCOHOL? _____

HOW DID YOU FIND OUT ABOUT ERKER'S KIRKWOOD, DR. GUBANY, DR. PASIERB?

NEWSPAPER TV RADIO REFERRAL FRIEND PHONE BOOK DIRECT MAIL

OTHER (PLEASE SPECIFY) _____

PAYMENT EXPECTED ON DAY OF VISIT, WE HAVE NO BILLNG SYSTEM

I HAVE RECEIVED A COPY OF THE ERKER'S KIRKWOOD PRIVACY POLICY.

SIGNATURE _____ DATE _____