

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

- | | |
|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat) | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Bone Marrow Transplantation | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> GERD | <input type="checkbox"/> 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 | <input type="checkbox"/> yes <input type="checkbox"/> no | joint pain | <input type="checkbox"/> yes <input type="checkbox"/> no |
| eye pain | <input type="checkbox"/> yes <input type="checkbox"/> no | stiffness | <input type="checkbox"/> yes <input type="checkbox"/> no |
| tearing | <input type="checkbox"/> yes <input type="checkbox"/> no | arthritis | <input type="checkbox"/> yes <input type="checkbox"/> no |
| eye redness | <input type="checkbox"/> yes <input type="checkbox"/> no | rash | <input type="checkbox"/> yes <input type="checkbox"/> no |
| fever or chills | <input type="checkbox"/> yes <input type="checkbox"/> no | changing moles | <input type="checkbox"/> yes <input type="checkbox"/> no |
| weight loss | <input type="checkbox"/> yes <input type="checkbox"/> no | headache | <input type="checkbox"/> yes <input type="checkbox"/> no |
| stuffy nose | <input type="checkbox"/> yes <input type="checkbox"/> no | seizure | <input type="checkbox"/> yes <input type="checkbox"/> no |
| ear ache | <input type="checkbox"/> yes <input type="checkbox"/> no | stroke | <input type="checkbox"/> yes <input type="checkbox"/> no |
| cough | <input type="checkbox"/> yes <input type="checkbox"/> no | paralysis | <input type="checkbox"/> yes <input type="checkbox"/> no |
| dry mouth | <input type="checkbox"/> yes <input type="checkbox"/> no | anxiety | <input type="checkbox"/> yes <input type="checkbox"/> no |
| high blood pressure | <input type="checkbox"/> yes <input type="checkbox"/> no | depression | <input type="checkbox"/> yes <input type="checkbox"/> no |
| rapid heart beat | <input type="checkbox"/> yes <input type="checkbox"/> no | diabetes | <input type="checkbox"/> yes <input type="checkbox"/> no |
| wheezing | <input type="checkbox"/> yes <input type="checkbox"/> no | thyroid abnormalities | <input type="checkbox"/> yes <input type="checkbox"/> no |
| shortness of breath | <input type="checkbox"/> yes <input type="checkbox"/> no | bleeding | <input type="checkbox"/> yes <input type="checkbox"/> no |
| upset stomach | <input type="checkbox"/> yes <input type="checkbox"/> no | anemia | <input type="checkbox"/> yes <input type="checkbox"/> no |
| diarrhea | <input type="checkbox"/> yes <input type="checkbox"/> no | allergies | <input type="checkbox"/> yes <input type="checkbox"/> no |
| constipation | <input type="checkbox"/> yes <input type="checkbox"/> no | hay fever | <input type="checkbox"/> yes <input type="checkbox"/> no |
| burning on urination | <input type="checkbox"/> yes <input type="checkbox"/> no | hives | <input type="checkbox"/> yes <input type="checkbox"/> no |
| urinary frequency | <input type="checkbox"/> yes <input type="checkbox"/> no | | |

Notice of Privacy Practices

Our privacy practices are available on our website (www.eyesbysavar.com) and on paper. I acknowledge that I was offered a copy of Dr. Savar's Notice of Privacy Practices.

and

Open Payments

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at: openpaymentsdata.cms.gov

Patient Signature: _____ Date: _____