PLANCHARD EYE & LASER CENTER

TODAY'S DATE: _____

Please fill out this form in its entirety.

SSN: _____

PATIENT NAME: _____ **DOB:** _____
LAST FIRST MI

GENDER: ____ **MARITAL STATUS:** S M D W **EMAIL:** _____
CIRCLE ONE

HOME PHONE: (_____)_____ **MOBILE PHONE:** (____)_____

HOME ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

OCCUPATION: _____ **EMPLOYER:** _____

EMPLOYER ADDRESS: _____

SPOUSE'S NAME: _____ **DOB:** _____ **SSN:** _____

SPOUSE'S OCCUPATION: _____

EMERGENCY CONTACT: _____ **EMERG PHONE:** (____)_____

NEXT OF KIN NAME: _____**PHONE**: (____)_____

NEXT OF KIN ADDRESS: _____

PRIMARY CARE PROVIDER: _____ **PCP PHONE:** (___)_____

PREFERRED PHARMACY: _____ **PHARM PHONE:** (___)_____

PHARMACY ADDRESS: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- ☐ Decline Response
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:

- ☐ Decline Response
- ☐ American-Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other
- ☐ Black or African American

Preferred Language: _____ ☐ Decline Response

PLEASE LIST ALL KNOWN ALLERGIES AND REACTIONS:

_____

_____

_____

Do you Currently Smoke? ☐ Y ☐ N **If no, Previously?** ☐ Y ☐ N Years Smoked: ____ Packs/Day _____

Do you use other tobacco products? ☐ Y ☐ N **Consume Alcohol?** ☐ Y ☐ N Drinks/Week? _____

FAMILY HISTORY/RELATIONSHIP TO PATIENT: Mother, Father, Grandparent, Siblings

☐ Cataracts		☐ High Blood Pressure	
☐ Glaucoma		☐ Arthritis	
☐ Macular Degeneration		☐ Cancer/Type/Location	
☐ Retinal Detachment		☐ Kidney Disease	
☐ Diabetes		☐ Stroke	
☐ Strabismus / Eye Muscle Problems		☐ Heart Attack / Heart Disease	
☐ Hereditary Eye Disease		☐ Thyroid Disease	
☐ Other:			

PLEASE LIST **ALL MEDICATIONS** (OR PROVIDE A LIST)

MEDICATION	DOSAGE	DIRECTIONS	PURPOSE OR CONDITION

Review of Systems **CHECK ALL THAT APPLY**

Ear, Nose, Mouth, Throat
- ☐ Hearing Problems
- ☐ Sinus Problems
- ☐ Throat or Mouth Problems

Cardiovascular - Heart
- ☐ Atrial Fibrillation
- ☐ Abdominal Aortic Aneurysm
- ☐ Angina (chest pain)
- ☐ Blood Clots (DVT)
- ☐ Carotid Artery Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ High Cholesterol
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypotension (Low Blood Pressure)
- ☐ Myocardial Infarction-Heart Attack
- ☐ Rheumatic Fever

Respiratory - Breathing
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ COPD
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Tuberculosis

Gastrointestinal Disease - Stomach
- ☐ Acid Reflux - Heartburn
- ☐ Colitis - Ulcerative
- ☐ Diverticulitis / Diverticulosis
- ☐ Gastric Stomach Ulcer
- ☐ Hiatal Hernia
- ☐ Irritable Bowel Syndrome (IBS)

Genitourinary
- ☐ Bladder Incontinence
- ☐ Chronic Dialysis
- ☐ Cystitis - UTI (Urinary Tract Infection)
- ☐ Enlarged Prostate
- ☐ Renal Insufficiency
- ☐ Renal Failure
- ☐ Uterine Disease

Integumentary Disease (Skin)
- ☐ Eczema
- ☐ Psoriasis

Musculoskeletal
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Polymyalgia

Neurological
- ☐ ADHD/ADD
- ☐ Alzheimer's
- ☐ Dementia
- ☐ Speech Delay
- ☐ Down Syndrome
- ☐ Cerebral Palsy
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Polio
- ☐ Neuropathy
- ☐ Parkinson's
- ☐ Fibromyalgia
- ☐ Seizure Disorder
- ☐ Mini Strokes (TIA)
- ☐ Stroke (CVA)

Hematologic/Lymphatic (Blood)
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Transfusions
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Malignant Hyperthermia

Endocrine
- ☐ Diabetes Mellitus
  - ☐ Insulin Dependent
  - ☐ Oral Meds
  - ☐ Diet Controlled
- ☐ Thyroid Disease

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Other Psychiatric Disorder

Allergic/Immunologic
- ☐ AIDS
- ☐ HIV
- ☐ Hay Fever
- ☐ Lupus Erythematosus
- ☐ Myasthenia Gravis
- ☐ Environmental Allergies

Cancer, or history of
- ☐ Bladder
- ☐ Breast
- ☐ Colon
- ☐ Hodgkin's
- ☐ Non-Hodgkin's
- ☐ Prostate
- ☐ Skin
- ☐ Basal Cell
- ☐ Squamous Cell
- ☐ Melanoma
- ☐ Leukemia
- ☐ Lung
- ☐ Lymphoma
- ☐ Ovarian
- ☐ Thyroid
- ☐ Uterine
- ☐ Other: _____

History of Infectious Disease
- ☐ Chicken Pox
- ☐ Herpes Zoster - Shingles
- ☐ MRSA
- ☐ Meningitis

Genetic Disorders
- ☐ Chromosome Abnormality
- ☐ Syndrome or identified genetic disease
- ☐ Retinitis Pigmentosa
- ☐ Color Blindness
- ☐ Other: _____

OTHER:

_____

_____

_____

_____

_____

Please list all Previous Surgical Procedures:

Past Ocular History: Do you have or have you had any of the following problems or conditions? Please answer **ALL** questions - Indicate **YES** or **NO**. **If the answer is yes, please provide a brief explanation**.

			Explanation
Glaucoma	☐ YES	☐ NO	_____
Cataract	☐ YES	☐ NO	_____
Droopy Eyelids	☐ YES	☐ NO	_____
Double Vision	☐ YES	☐ NO	_____
Dry Eye	☐ YES	☐ NO	_____
Tearing	☐ YES	☐ NO	_____
Lazy Eye	☐ YES	☐ NO	_____
Crossed Eyes	☐ YES	☐ NO	_____
Macular Degeneration	☐ YES	☐ NO	_____
Retinal Detachment	☐ YES	☐ NO	_____
Eye Injury	☐ YES	☐ NO	_____
Eye Inflammation	☐ YES	☐ NO	_____
Thyroid eye disease/ Graves' Disease	☐ YES	☐ NO	_____
Laser Surgery	☐ YES	☐ NO	_____
Other	☐ YES	☐ NO	_____

Previous eye surgery? What kind(s)? ☐ YES ☐ NO

_____

☐ **Previous face, brow, eyelid, tear duct, or orbital surgery?** _____

Latex allergy? ☐ YES ☐ NO **Sensitive to Soaps?** ☐ YES ☐ NO **Tapes?** ☐ YES ☐ NO

Do you ever take Aspirin, Plavix, Coumadin, Lovenox? ☐ YES ☐ NO

Have you ever taken: Flomax, Tamsulosin, Uroxatral, or Cardura? ☐ YES ☐ NO

Problems tolerating anesthesia? ☐ YES ☐ NO _____