

DURRIE VISION

See a dramatic difference.

PATIENT INFORMATION

Date _____

Legal Name _____
Dr/Mr/ Mrs/ Ms/ Miss Last First Middle Name

Nickname _____ Date of Birth _____ SS# _____

Street Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Other/Cell Phone _____

Email address _____ Sex: M or F

Employer _____ Occupation/ Job Title _____

Emergency Contact _____ Emergency Phone _____

Primary Care Physician _____ Primary Care Physician Phone _____

Who referred you to our Practice? _____

Was the referral by a medical doctor? Yes or No Was the referral by an eye doctor? Yes or No

Please provide the name and address of your referral (if possible) _____

I have been informed of the Privacy Practices and Patient Bill of Rights and have received a copy.

Signature of Patient or Personal Representative _____ Date _____

Patient Agreement

I understand that payment is due at the time of service. I certify that the information provided on all forms is correct. I authorize the release of medical information to this organization. I authorize my physician to prescribe medication and to give me reasonable and proper medical care by today's standards. This agreement is in effect until revoked in writing by the patient.

Signature of Patient or Personal Representative _____ Date _____

Health History

Name: _____ **Date:** _____

Please list all medications you are currently taking: _____

Ocular History

Have you ever been diagnosed with any of the following eye problems, please include which eye if applicable, using R for right eye, L for left eye, and B for both eyes.

Amblyopia/Lazy Eye Dry Eye Iritis
 Cataracts Fuch's Dystrophy Keratoconus
 Corneal Scar Glaucoma Macular Degeneration
 Diabetic Retinopathy Injury/Trauma Retinal Detachment/Tear
 Other _____

Have you had any eye surgeries? Yes or No

Surgery	Eye	Date	Doctor
Cataract			
CK			
Corneal Transplant			
Lasik			
Lid Surgery			
LTK			
PRK			
RK			
Retinal Detachment Repair			
Strabismus/Muscle Surgery			
Yag Laser			
Other			

Personal History

Have you ever been treated for any of the following medical conditions?

AIDS Diabetes (insulin dependent) Migraines
 Anesthesia Complications Diabetes (non-insulin dependent) Multiple Sclerosis
 Anxiety Emphysema Muscular Dystrophy
 Asthma Epilepsy Paraplegia
 Back Problems Fibromyalgia Quadriplegia
 Bipolar Disorder Heart Disease Rosacea
 Cancer Hepatitis A or B or C Seasonal Allergies
 Cerebral Palsy Herpes Simplex Seizures
 Cervical Fracture High Cholesterol Stroke
 Depression Hypertension Thyroid Dysfunction
 Lupus Other _____

Do you currently have any of the following?

- Cochlear Implants
- Internal Defibrillator
- Pacemaker

Are you currently pregnant or breastfeeding? Yes or No _____

In the last 5 years, have you had any surgeries? Yes or No

If so, please list and include date of surgery _____

Patient Allergies

Please list all medications you are allergic to: _____

Are you allergic to:

- Tape
- Latex
- Iodine/Betadine

Family Medical History

Do any of your grandparents, parents, or siblings have any of the following?

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Adopted | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Retinal Detachment or Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> Other _____ |

Social History

Do you drink? Yes or No How Often? _____

Do you smoke? Yes or No How Often? _____

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