Last Name:________________________________ **First Name:**_______________________________ **MI:**_____

Address:_________________________________ **City:**_____________________ **State:**______ **Zip:**________

Home Phone:______________________________ **Cell Phone:**____________________________________

DOB: __________________ **Social Security No:**______-_____-_______ **Gender:** Male Female

Marital Status: Single Married Divorced Widowed Other

Race: American Indian or Alaska Native Asian Black or African American White

Native American or Other Pacific Islander Decline to Answer

Ethnicity: Hispanic or Latino Non- Hispanic or Latino Unknown

Emergency Contact:_______________________ **Emergency Contact#:**______________________________

Relationship:________________________

Pharmacy:__________________ **Address:**_________________________ **Phone:**_____________________

Referring Physician:____________________________________ **Phone:** ______________________________

Address:_________________________________ **City:**_____________________ **State:**______ **Zip:**________

Primary Care Physician:___________________________________ **Phone:**_________________________

Address:_________________________________ **City:**_____________________ **State:**______ **Zip:**________

Other Physician:_____________________________________ **Phone:** ___________________________

Address:_________________________________ **City:**_____________________ **State:**______ **Zip:**________

Please list any other Doctor's needing reports regarding your eye care:

Primary Insurance:_________________________ Effective Coverage Date:______________

ID #:________________________________ Group #:__________________________

Subscriber:______________________ DOB:_________ Relationship:_________________

Secondary Insurance:_______________________ Effective Coverage Date:_____________

ID #:________________________________ Group #:__________________________

Subscriber:______________________ DOB:_________ Relationship:_________________

MEDICAL INFORMATION

Patient Name:________________________________ **Today's Date:**______________

Have you had any of the following? If YES, when? Providing Physician?

Cataract Surgery and Date: Right Eye_______________ Left Eye_______________

Retinal Laser/Surgery and Date: Right Eye_______________ Left Eye_______________

Macular Degeneration: Y N If yes, prior treatment(s):____________________________

Glaucoma: Y N If yes, prior treatment(s):____________________________

Diabetic Retinopathy: Y N If yes, prior treatment(s):____________________________

Any other (non- eye related) surgeries:

Insurance Authorization: I hereby assign all medical and/or benefits to which I am entitled, including Medicare or any other private health plan to Sinclair Retina Associates, P.C. This assignment is considered as valid as an original. I understand that I am financially responsible for any amount not covered by insurance or any amount deemed the subscriber's responsibility as defined by my insurance company, particularly co-payments and deductibles.

PATIENT SIGNATURE:_____________________________ DATE__________________

Allergies: Please **CHECK** or **LIST ALL** Allergies

None **Penicillin** **Sulfa** **Fluorescein** **Shellfish** **Latex** **Iodine**

Other:

Please list **ALL ORAL and/or INJECTABLE Medications, Vitamins or Supplements** you are **CURRENTLY** taking:

Please list **ALL Eye Drops** you are **CURRENTLY** Using**:**

Family Medical & Eye History

Have any of your family members had any of the following? Please circle **YES** or **NO** or and list which **blood relative(s)** had/ have the condition:

Macular Degeneration: **Y** **N** ________________________

Diabetic Retinopathy: **Y** **N** ________________________

Retinal Detachment: **Y** **N** ________________________

Glaucoma: **Y** **N** ________________________

Blindness: **Y** **N** ________________________

Other Significant Eye Diseases: _________________________________

Diabetes: **Y** **N** ________________________

Heart Disease: **Y** **N** ________________________

High Blood Pressure: **Y** **N** ________________________

Stroke: **Y** **N** ________________________

Cancer: **Y** **N** **(type)**________________________

Other:

____ **I do not know my family history**

SRA

Social History

What is your Occupation?________________________________ Are you still working? **Y** **N**

Do you **CURRENTLY** smoke cigarettes/cigars? **Y** **N** If yes, how many packs per day?______

When did you start smoking?______

Are you a **FORMER** smoker? **Y** **N** If so, what was your maximum packs per day?_______

How many years did you smoke for?_______ Year Quit:_________

Do you drink alcohol? **Y** **N**

(if Yes, how much) Socially/Occasionally 1-2/ Day 3-4/ Day +4/ Day

Any **Past** or **Present** substance abuse? **Y** **N**

(This information is important for medication interactions)

Have you had a blood transfusion since 1977? **Y** **N** If so, When?______________________

Is there anything that we failed to mention on this form that you would like the Doctor to be aware of?

Y **N**

Your eyes will be dilated for your exam. Dilation will cause the size of your pupils to be enlarged for several hours and can cause glare, blurred vision, and light sensitivity during that time. We suggest you bring dark glasses with you to have upon completion of exam.

PATIENT SIGNATURE:____

DATE:________________

Please complete this form in its entirety. It is important to fill in as much information as you can regarding any condition that pertains to you. Please provide us with a year, or approximation of time you have had any of the following medical problems, or an approximate year of diagnosis. Please make sure to check, “Yes” or “No,” next to each problem.

SRA

YES	NO	
		General
		Recent Weight Loss ____
		Lack of Energy ____
		Trouble sleeping ____
		Other ____
		Eyes
		Vision loss ____
		Changes in vison ____
		Eye Pain ____
		Other ____
		Ears, Nose & Throat
		Hearing Loss ____
		Sinus Problems ____
		Infections ____
		Other ____
		Cardiovascular
		Heart Attack ____
		High Blood Pressure ____
		High Cholesterol ____
		Heart Murmur ____
		Irregular Heart Beat ____
		Mitral Valve Prolapsed ____
		Chest Pain ____
		Circulation Problems ____
		Other ____
		Respiratory
		Asthma ____
		Bronchitis ____
		Emphysema ____
		Tuberculosis ____
		Pneumonia ____
		Other ____
		Gastrointestinal
		Ulcers ____
		Diverticulitis ____
		Crohn's Disease ____
		Hepatitis ____
		Other ____
		Genitourinary (Kidney, Bladder, Prostate)
		Kidney Disease ____
		Kidney Dialysis ____
		Cancer ____
		Urinary Infections ____
		Other ____

YES	NO	
		Musculoskeletal
		Arthritis ____
		Osteoporosis ____
		Muscle Pain ____
		Other ____
		Integumentary (Skin/Breast)
		Rashes/ Sensitivities ____
		Rosacea ____
		Skin Cancer ____
		Breast Cancer ____
		Other ____
		Neurological (Nervous System & Brain)
		Seizure ____
		Stroke ____
		Paralysis/ Weakness ____
		Parkinson's Disease ____
		Alzheimer's ____
		Numbness ____
		Migraines ____
		Other ____
		Psychiatric (Mental Illness)
		Depression ____
		Psychosis ____
		Mania, bipolar ____
		Anxiety ____
		Other ____
		Endocrine System
		Diabetes (if YES see below)*
		Thyroid Disease ____
		Other ____
		Hematologic/ Lymphatic (Blood)
		Anemia ____
		Excessive Bleeding ____
		Bruising easily ____
		Clotting Problems ____
		Other ____
		Allergic/Immunologic
		Lupus ____
		Arthritis ____
		HIV ____
		Other ____
		***Diabetes**
		When were you diagnosed? ____
		Are you on insulin? ____ (pump or monitor?)
		Date/Year you started insulin? ____
		What was your last Hgb A1C? ____ Date: ____
		Do you test your blood sugar at home?
		Average Daily Range? ____ to ____

PATIENT SIGNATURE ____________________ **DATE** ____________