

**SHORT HILLS OPHTHALMOLOGY GROUP**

DATE: \_\_\_\_\_

LAST NAME : \_\_\_\_\_ FIRST NAME : \_\_\_\_\_

TITLE: MR: \_\_\_\_\_ MRS: \_\_\_\_\_ MS: \_\_\_\_\_ DR: \_\_\_\_\_

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SS# \_\_\_\_\_

PHONE # \_\_\_\_\_ CELL# \_\_\_\_\_

EMAIL : \_\_\_\_\_ MAY WE EMAIL YOU? YES \_\_\_ NO \_\_\_

HOME ADDRESS: \_\_\_\_\_ APT# \_\_\_\_\_

CITY \_\_\_\_\_ STATE: \_\_\_\_\_ ZIPCODE: \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

WORK PHONE NUMBER: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE# \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

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**PRIMARY (FIRST INSURANCE)**

**SECONDARY INSURANCE**

INSURANCE COMPANY NAME: \_\_\_\_\_

POLICYHOLDER NAME: \_\_\_\_\_

RELATIONSHIP TO PT.: \_\_\_\_\_

INSURANCE ID#: \_\_\_\_\_

POLICYHOLDER'S DATE OF BIRTH: \_\_\_\_\_

POLICYHOLDER'S SS#: \_\_\_\_\_

POLICYHOLDER'S EMPLOYER: \_\_\_\_\_  
(IF RETIRED PLEASE WRITE RETIRED AND FROM WHAT COMPANY)

MEDICAL DR. NAME: \_\_\_\_\_

MEDICAL DR. ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

MEDICAL DR. PHONE#: \_\_\_\_\_

**PATIENT HISTORY RECORD**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICAL HISTORY:**

OCCUPATION: \_\_\_\_\_

**LIST ALL CURRENT AND PAST MEDICAL CONDITIONS FOR WHICH YOU ARE BEING OR HAVE BEEN TREATED FOR:**

\_\_\_\_\_

**LIST ALL HOSPITALIZATIONS AND SURGERIES:**

\_\_\_\_\_

**DESCRIBE ANY FAMILY HISTORY OF MEDICAL CONDITIONS:**

\_\_\_\_\_

**LIST ALL CURRENT MEDICATIONS:**

\_\_\_\_\_

\_\_\_\_\_

**LIST ANY FOOD OR DRUG ALLERGIES:**

\_\_\_\_\_

**PLEASE CHECK OFF ALL INFORMATION PERTAINING TO YOUR MEDICAL HISTORY AND EXPLAIN IN THE SPACES PROVIDED:**

- CHRONIC FEVER, UNEXPECTED WEIGHT LOSS/GAIN, FATIGUE

EXPLAIN: \_\_\_\_\_

- EAR/NOSE/THROAT PROBLEMS (HEARING LOSS, SINUS PROBLEM)

EXPLAIN: \_\_\_\_\_

- HEART PROBLEMS (CHEST PAIN, IRREGULAR HEARTBEAT)

EXPLAIN: \_\_\_\_\_

- RESPIRATORY PROBLEMS (SHORTNESS OF BREATH, COUGH, ETC)

EXPLAIN: \_\_\_\_\_

- GASTROINTESTINAL (HEARTBURN, ABDOMINAL PAIN, VOMITING)

EXPLAIN: \_\_\_\_\_

- URINARY PROBLEMS (PAIN, DISCOMFORT, BLOOD IN URINE)

EXPLAIN: \_\_\_\_\_

- SKIN PROBLEMS (RASHES, DRYNESS)

EXPLAIN: \_\_\_\_\_

- MUSCULOSKELETAL PROBLEMS (ACHES, JOINT PAIN, SWELLING)

EXPLAIN: \_\_\_\_\_

- NEUROLOGIC PROBLEMS (NUMBNESS, WEAKNESS, HEADACHES, PARALYSIS)

EXPLAIN: \_\_\_\_\_

- PSYCHIATRIC PROBLEMS (DEPRESSION, ANXIETY)

EXPLAIN: \_\_\_\_\_

\_\_\_\_\_

DO YOU SMOKE? Y / N QUANTITY \_\_\_\_\_

DO YOU DRINK ALCOHOL? Y / N QUANTITY \_\_\_\_\_

#### OCULAR HISTORY

DATE OF LAST EYE EXAM: \_\_\_\_\_  
OPHTHALMOLOGIST (M.D.) / OPTOMETRIST (O.D.) / DON'T KNOW

HAVE YOU EVER BEEN TREATED FOR AN EYE CONDITION PREVIOUSLY? (INFECTIONS, ACCIDENTS) Y / N EXPLAIN \_\_\_\_\_

HAVE YOU EVER HAD SURGERY ON YOUR EYES, INCLUDING LASER AND LASER VISION CORRECTION? Y / N EXPLAIN \_\_\_\_\_

IS THERE A FAMILY HISTORY OF SERIOUS EYE DISEASE (GLAUCOMA, RETINAL DISEASE, BLINDNESS FOR ANY REASON? Y / N  
EXPLAIN \_\_\_\_\_

DO YOU WEAR GLASSES? Y / N READING? Y / N DISTANCE? Y / N BOTH? Y / N  
AGE OF CURRENT PRESCRIPTION: \_\_\_\_\_

ARE YOU INTERESTED IN FINDING OUT ABOUT LASER VISION CORRECTION? Y / N

DO YOU WEAR CONTACT LENSES? Y / N

TYPE (DAILY DISPOSABLE, 2 WEEK DISPOSABLE, MONTHLY, YEARLY)

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PRESCRIPTION, IF AVAILABLE (BRAND, STRENGTH, BASE CURVE , DIAMETER)

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USUAL CLEANING METHOD: \_\_\_\_\_

DO YOU SLEEP IN YOUR CONTACT LENSES? Y / N HOW OFTEN? \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

MD SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

MD COMMENTS: