

Source of information

Your relationship to the patient? _____
Primary Care Physician _____
Referring Physician? _____

Reason for patient visit

Eyes turn in or out? Yes or No
Decreased vision? Yes or No
Red eye? Yes or No
Increased Tearing? Yes or No
Eye Pain? Yes or No
Injury to eye? Yes or No

History of current eye problem

When did symptoms begin? _____
Has the problem changed over time? Yes or No
Does anything change the problem? Yes or No

Past Eye History

Has patient ever had an eye exam? Yes or No
How long ago _____
Does patient wear glasses? Yes or No
Has patient ever patched an eye? Yes or No
Which eye? _____ For how long? _____
Has patient ever had an injury to the eye?
Yes or No What/when _____
Has patient had eye surgery? Yes or No
What /When? _____
Does patient your eye medication? Yes or No
What/How often? _____

Past Medical History

Is patient allergic to medicine or latex?
Yes or No What? _____
Is patient taking any medication daily?
If yes what? _____
Has patient ever been hospitalized?
Yes or No

Does the patient have any medical problems?
Yes or No What? _____
Has patient ever had a serious illness/injury?
If yes what? _____
Has your child ever had an operation?
If yes what? _____
Does the patient go to school or work? _____
Who does the patient live with? _____

Past Medical History for Child ONLY

Are immunizations up to date?
Yes or No If not why? _____
Was child born prematurely? Yes or No
Child's birth weight: _____ lbs _____ oz

Does anyone in the family have eye problems?

Eye disease? Yes or No
Eyes crossing? Yes or No
Did anyone in family have eye problems as a child?
Yes or No

Reviews of Systems

Headache Yes or No
Seizures Yes or No
Ear/Nose/Throat problems Yes or No
Thyroid problems Yes or No
Heart Problems Yes or No
Birth Defects Yes or No
Asthma/Breathing problems Yes or No
Cancer Yes or No
HIV Yes or No
Stomach Problems Yes or No
Diabetes Yes or No
Liver Problems Yes or No
Bleeding Problems Yes or No
Muscular Dystrophy Yes or No
Multiple Sclerosis Yes or No
Skin Problems Yes or No
Arthritis Yes or No
Immune Problems Yes or No
High Blood Pressure Yes or No
Stroke Yes or No

Child Patient Information Sheet

****If you are an adult patient please
fill out the next page.****

1. Tell us about your child

Today's date: _____

Child's Name: _____

Male Female

Child's DOB ___/___/___ Age: _____

Child's Home# _____

SS# _____

Child's Home Address: _____

City, State Zip Code

2. Who is Accompanying the child today?

Name: _____

Relation: _____

Who referred you? _____

Who is the Pediatrician? _____

Who is the Ophthalmologist? _____

Other family members seen by us: _____

3. Mother's Information

Name: _____

Guardian Step Mother

DOB: _____

Wk#: _____

Employer: _____

SS# _____

** Dr. Crnic would like to keep you updated on things going on with her practice. Please feel free to add your E-mail address below. _____

4. Father's Information

Name: _____

Guardian Step Father

DOB: _____

Wk#: _____

Employer: _____

SS# _____

5. Primary Medical Ins.

Ins. Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone: _____

Group# _____

Policy# _____

Who is the Subscriber? _____

DOB of Subscriber: _____

SS# of Subscriber: _____

Employer of Subscriber: _____

6. Secondary Medical Ins.

Ins. Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone: _____

Group# _____

Policy# _____

Who is the Subscriber? _____

DOB of Subscriber: _____

SS# of Subscriber: _____

Employer of Subscriber: _____

Adult Patient Information Page

1. Dear patient, please tell us about yourself,

Your name: _____

Male Female

Your DOB ___/___/___ Age: _____

Your home telephone# _____

Social Security# _____

Your home Address: _____

City, State Zip Code

Your email address _____

Emergency Contact

(not living with Patient) _____

Dattime telephone number _____

2. Primary Medical Ins.

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group# _____

Policy# _____

Who is the Subscriber? _____

Date of birth of Subscriber: _____

Social Security # of Subscriber: _____

Employer of the Subscriber: _____

3. Secondary Medical Ins.

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group# _____

Policy# _____

Who is the Subscriber? _____

Date of birth of Subscriber: _____

Social Security # of Subscriber: _____

Employer of Subscriber: _____