Dr. Richard A. Greene
Anastasia Eye Associates
Patient History and Information

Patient Name (First) _____ (MI) _____ (Last) _____

Prefer to be called? _____ Reason for visit today? _____

Address: _____ City/State _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Male: __ Female: __Date of Birth: ___/___/_____ Social Security #: _____

Email address: _____ Permission to use email?:_____

Height: _____ Weight: _____ Primary Care Physician: _____

Emergency Contact: _____ Relationship:_____

Phone # of Emergency Contact: _____

Primary Insurance Company: _____

ID or Member #: _____ Group #:_____

Name of Primary Insured: _____ Insured's DOB: ____/____/_____

Secondary Insurance Company (if applicable): _____

ID or Member #: _____ Group #:_____

Name of Primary Insured: _____ Insured's DOB: ____/____/_____

CURRENT EYE SYMPTOMS

Last Vision Exam: _____

ASTHENOPIC

YES	NO		YES	NO	
_____	_____	Glare Sensitivity	_____	_____	Eye Pain/Soreness
_____	_____	Headaches	_____	_____	Foreign Body Sensation
_____	_____	Light Sensitivity			
_____	_____	Tired Eyes	_____	_____	Infection of Eyelid
		PHYSIOLOGIC	_____	_____	Itching
_____	_____	Burning	_____	_____	Mucous
_____	_____	Dryness	_____	_____	Ptosis (drooping eyelid)
_____	_____	Eyelid Swelling			
			_____	_____	Redness

CURRENT EYE SYMPTOMS (continued)

YES	NO		YES	NO	
_____	_____	Sandy or Gritty Feeling	_____	_____	Floaters or Spots
		VISUAL SYMPTOMS	_____	_____	Fluctuating Vision
_____	_____	Blurred Vision Distance	_____	_____	Loss of Central
_____	_____	Blurred Vision Near			Vision
_____	_____	Distorted Vision	_____	_____	Loss of Side Vision
_____	_____	Double Vision	_____	_____	Loss of Vision
_____	_____	Flashes of Lights			

CURRENT EYE DISEASES

YES	NO		YES	NO	
_____	_____	Amblyopia	_____	_____	Glaucoma
_____	_____	Blepharatis	_____	_____	Glaucoma Suspect
_____	_____	Blindness	_____	_____	High Risk Meds
_____	_____	Cataracts	_____	_____	Macular Degeneration
_____	_____	Color Blindness	_____	_____	PVD (Floating Spots)
_____	_____	Diabetic Retinopathy	_____	_____	Retinal Detachment
_____	_____	Dry Eye	_____	_____	Strabismus
_____	_____	Eye Injuries			

CURRENT MEDICATIONS

Name of Medication	For Treatment of?

ALLERGIES TO MEDICINES?

Name of Medication	Type of Reaction

PAST EYE SURGERIES (include dates)

_____

_____

HEALTH HISTORY

Last Health Exam: _____

YES	NO		YES	NO	
_____	_____	**Fever**	_____	_____	**Rosacea**
_____	_____	**Fatigue**	_____	_____	**Shingles**
			_____	_____	**Skin Cancer**
_____	_____	**Hearing Loss**			
_____	_____	**Sinus Disorders**			
			_____	_____	**Multiple Sclerosis**
_____	_____	**Atrial Fibrillation**	_____	_____	**Frequent Headaches**
_____	_____	**Heart Disease**	_____	_____	**Convulsions/Seizures**
_____	_____	**Hypertension**	_____	_____	**Memory Loss**
_____	_____	**Stroke/TIA**	_____	_____	**Depression**
_____	_____	**Asthma**	_____	_____	**Diabetes**
_____	_____	**Emphysema (COPD)**		**What Type?:**	_____
			_____	_____	**Thyroid Disease**
_____	_____	**Flomax Use**	_____	_____	**Anemia**
			_____	_____	**Cholesterol**
_____	_____	**Arthritis**	_____	_____	**Seasonal Allergies**
_____	_____	**Muscle/Joint Pain**	_____	_____	**Lupus**
_____	_____	**Back Pain**			
			_____	_____	**Pregnant?**
_____	_____	**Herpes**	_____	_____	**Nursing?**
_____	_____	**Rash/Itching**			
_____	_____	**Other**			

_____

FAMILY HISTORY

YES	NO	RELATIONSHIP	DISEASE
_____	_____	_____	Amblyopia (Lazy Eye)
_____	_____	_____	Blindness
_____	_____	_____	Cataracts
_____	_____	_____	Color Blindness
_____	_____	_____	Glaucoma
_____	_____	_____	Macular Degeneration
_____	_____	_____	Retinal Detachment
_____	_____	_____	Strabismus
_____	_____	_____	Arthritis
_____	_____	_____	Cancer
			Type:_____
_____	_____	_____	Diabetes
			Type:_____
_____	_____	_____	Heart Disease
_____	_____	_____	High Blood Pressure
_____	_____	_____	Kidney Disease
_____	_____	_____	Lupus
_____	_____	_____	Stroke
_____	_____	_____	Thyroid Disease
_____	_____	_____	Other: _____

CURRENT OCCUPATION:_____ YEARS?_____

EMPLOYER: _____

PLEASE ANSWER THE FOLLOWING:

YES	NO	
_____	_____	Do you drink alcohol? if yes, how much?
		_____ occasional __ 1 per day ___2-3 per day
_____	_____	Do you smoke? if yes, how much
		_____ occasional ___1/2 pack per day ___1 pack per day
		_____ 1+ pack per day
_____	_____	If you do not smoke, did you ever?
		If a former smoker, when did you quit? _____

_____ _____

Date **Signature of Patient**