

We are participating in the government's Meaningful Use Requirements Program, which is intended to improve care coordination and ensure security and privacy provisions for personal health information.

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Nickname) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: M  F  Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #'s: (H) \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (W) \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (C) \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Do you have Internet access?  YES  NO Email Address: \_\_\_\_\_

What is your preferred method of communication? Cell  Work  Home  Email  Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Tele: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

General Practitioner: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Pharmacy Name/Address \_\_\_\_\_ Pharm. Phone# \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Smoking Status:**  Current, every day smoker  Current, part-time smoker  Former smoker  
 Smoker  Never smoked  Current status unknown  Unknown if ever smoked

If you do smoke, how many a day? \_\_\_\_\_

**Race:**  White  Asian  Black or African American  Native Hawaiian or Pacific Islander  
 American Indian or Alaskan Native

**Ethnicity:**  NOT Hispanic or Latino  Hispanic or Latino **Preferred Language:** \_\_\_\_\_

Reason for Visit Today & Symptoms: \_\_\_\_\_

List any previous eye problems or eye surgery: \_\_\_\_\_

Circle correct: Employed/Retired/Student/Unemployed - Employer: \_\_\_\_\_

Marital Status (circle): Married/Divorced/Separated/Widowed/Single/Partner/Child

How did you hear about us?  Phone Book  Website: [www.piedmontretina.com](http://www.piedmontretina.com)  Other: \_\_\_\_\_

Friend/Relative \_\_\_\_\_

Please provide your friend/relative's name so we may thank them for referring you to us ☺

**Do you have, or have you ever been diagnosed with any of the following?**

**Please provide details if "Yes" checked.**

YES  NO Diabetes \_\_\_\_\_

YES  NO High Blood Pressure \_\_\_\_\_

YES  NO Heart Disease \_\_\_\_\_

YES  NO Respiratory Disease \_\_\_\_\_

YES  NO Gastrointestinal Disease \_\_\_\_\_

YES  NO Liver Disease or Hepatitis \_\_\_\_\_

YES  NO Prostate Disease \_\_\_\_\_

YES  NO Cancer \_\_\_\_\_

YES  NO Kidney Disease \_\_\_\_\_

YES  NO HIV, Infectious Disease \_\_\_\_\_

**List medications, including dose:**

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**List eye drops that you are currently using:**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Please list any drug allergies or note below if you are allergic to Latex or adhesives.**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Please check any of the listed symptoms that you are currently experiencing:**

- |  |   |  |
|--|---|--|
| feeling poorly <input type="checkbox"/>      | lack of energy <input type="checkbox"/>                               | fever/ chills <input type="checkbox"/> |
| trouble seeing <input type="checkbox"/>      | trouble hearing <input type="checkbox"/>                              | chest pain <input type="checkbox"/>    |
| shortness of breath <input type="checkbox"/> | nausea <input type="checkbox"/>                                       | vomiting <input type="checkbox"/>      |
| diarrhea <input type="checkbox"/>            | weakness <input type="checkbox"/>                                     | rash <input type="checkbox"/>          |
| depression <input type="checkbox"/>          | difficulty with speech, memory, or cognition <input type="checkbox"/> |  |

**Has anyone in your family ever been diagnosed with any of the following>**

- |  |   |  |
|--|---|--|
| Diabetes <input type="checkbox"/>      | Macular Degeneration <input type="checkbox"/> | Retinal Disease <input type="checkbox"/> |
| Glaucoma <input type="checkbox"/>      | Cataracts <input type="checkbox"/>            | Cancer <input type="checkbox"/>          |
| Heart Disease <input type="checkbox"/> | Stroke <input type="checkbox"/>               |  |

Do you drink alcohol? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Height: \_\_\_\_\_ Ft \_\_\_\_\_ Inches    Weight: \_\_\_\_\_

Additional Data:

- HIV     MRSA     HEP A     HEP B     HEP C

Blood Pressure \_\_\_\_\_/ \_\_\_\_\_ (for office use)