PIEDMONT RETINA SPECIALISTS, P.A.

Patient Information

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)_____ (Prefix)_____ (Suffix)_____

Date of Birth _____/_____/_____ **Gender:** M □ F □ **Social Security Number** _____-_____-_____

Address _____ **Apt** _____ **City** _____

State_____ **Zip Code**_____**Email** _____

Phone Number (Home) _____-_____-_____(Mobile) _____-_____-_____ (Work) _____-_____-_____

Emergency Contact_____ **Emergency Contact**_____

Relationship_____ **Relationship**_____

Phone _____-_____-_____ **Phone** _____-_____-_____

General Practitioner _____ **Referring Doctor** _____

Pharmacy Name _____**Pharmacy Phone Number** _____-_____-_____

Pharmacy Address _____ **City** _____

Race: □ White □ Asian □ Black/African American □ Native Hawaiian/Pacific Islander □ American Indian/Alaskan Native
Ethnicity : □ NOT Hispanic or Latino □ Hispanic or Latino **Preferred Language:**_____

Please Circle: Employed/Retired/Student/Unemployed – Employer _____

Marital Status: Married/Divorced/Separated/Widowed/Single/Partner/Child

Reason for Visit Today & Symptoms _____

History of Cataract Surgery (Date and Doctor) _____

Previous Retina Treatment (including surgery, lasers and/or injections)_____

_____

Do you have, or have you ever been diagnosed with any of the following?
Please provide details if "Yes" checked.

□ YES □ NO Diabetes: Type 1 □ or Type 2 □ A1C: _____ Last Blood Sugar: _____
□ 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 Cancer_____
□ YES □ NO Kidney Disease_____
□ YES □ NO Neurological Disease or Stroke _____
□ YES □ NO HIV, Infectious Disease_____

Other Medical Condition(s):

_____

_____

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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 <u>currently</u> experiencing:

Weight Loss □	Fatigue □	Fever □	Trouble Seeing □
Eye Pain □	Trouble Hearing □	Throat Pain □	Chest Pain □
Rapid Heartbeat □	Shortness of Breath □	Cough □	Nausea □
Vomiting □	Diarrhea □	Muscle Pain □	Arthritis □
Rash □	Non-healing Wounds □	Depression □	Anxiety □

Difficulty with Speech, Memory, or Cognition □

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

Diabetes □ Macular Degeneration □ Retinal Disease □ Glaucoma □

Cataracts □ Cancer □ Heart Disease □ Stroke □

Do you drink alcohol? _____ If yes, how much?_____

Height _____ **Weight** _____

<u>Smoking Status</u> □ 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? _____

<u>Additional Data</u>

□ HIV □ MRSA □ HEP A □ HEP B □ HEP C