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 #: _____-_____-_____

Address: _____City: _____State:_____Zip: _____

Phone #'s: (H) ____-____-_____ (C) ____-____-_____ (W) ____-____-_____

Email Address:_____

What is your preferred method of communication? Cell □ Work □ Home □

Emergency Contact: _____Relationship: _____Tele:____-____-_____

General Practitioner: _____ Referring Doctor:_____

Pharmacy Name/Address_____ Pharm. Phone# ____-____-_____

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

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 Neurological Disease_____
□ YES □ NO Cancer_____
□ YES □ NO Kidney Disease_____
□ 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:

feeling poorly □ lack of energy □ fever/ chills □

trouble seeing □ trouble hearing □ chest pain □

shortness of breath □ nausea □ vomiting □

diarrhea □ weakness □ rash □

depression □ 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: _____Ft _____Inches Weight: _____

<u>Smoking Status:</u> □Current, every day smoker □Current, part-time smoker □Former smoker
□Never smoked □Unknown if ever smoked

If you do smoke, how many a day? _____

<u>Additional Data:</u>

□ HIV □ MRSA □ HEP A □ HEP B □ HEP C