

Jackson Eye Associates

PATIENT'S INFORMATION: (Please fill form out completely)

Today's Date: _____

Last Name First Name MI Date of Birth Age

Social Security Number Married / Widowed/ Single/ Other _____
Circle one: Marital Status Occupation / Retired? Employer

English/ Spanish/ _____ Mail / Phone/ Email/Text Message YES / NO _____
Preferred Language: Other? Contact Preference : (Circle) Would you like email updates? If so please give Email Address

Gender: Male / Female **Race:** White /African Amer/Amer Indian/ Asian / Hispanic-Latino/ other? _____

Ethnicity: American / Mexican / Japanese / Chinese/ Asian / European / Latino/ other? _____

Patient's Home Address City State Zip code

() _____ () _____ () _____
Home Phone Work Phone/ Extension Cell Phone Alt. Phone #/ Who's Number or Type?

Patient's Employer Address City State / Zip Phone Number

Spouse's Full name Spouse's SSN # Spouse's DOB Spouse's Age Spouse's Cell #

Spouse's Employer Spouse's Employer Address City State/Zip Spouse's Work #

DO YOU HAVE AN "ADVANCED DIRECTIVE?":

YES or NO _____ Living Will / Organ-Tissue Donor / Durable Power of Attorney / Do Not Resuscitate (DNR)
Circle Circle Type of Directive

REFERRED BY: Yellow pages / Radio / Newspaper / Internet / Friend / Dr. _____ / Other: _____
Circle or Fill in Name of referring Source

EMERGENCY CONTACT : (IF UNABLE TO REACH PATIENT)

Name Relationship Home Phone Cell Phone Work Phone / Extension

IF PATIENT IS A MINOR: PLEASE COMPLETE):

Mother's Full Name Social Security # Date of Birth Phone # Cell or Home?

Mother's Employer Work Phone # and Ext Home Address if different from Above

Father's Full Name Social Security # Date of Birth Phone # Cell or Home?

Father's Employer Work Phone # and Ext Home Address if different from Above

COMPLETE OTHER SIDE GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST TO COPY

Name: _____ **Date of Birth:** _____ **Age:** _____ **Date:** _____
Height: _____ **Weight:** _____ **Sex:** Male / Female **Primary Care Physician:** _____

CONDITIONS:	Circle any and all conditions that apply to you <u>or</u> check none.	NONE
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches	
EARS, NOSE, THROAT:	hard of hearing, ear ache, cough, dry mouth, sinus/allergy, hoarseness, vertigo	
CARDIOVASCULAR:	high B/P, heart attack, chest pain, congestive heart failure, racing pulse, high cholesterol, irregular heartbeat, palpitations, pace maker	
RESPIRATORY:	congestion, wheezing, short of breath, asthma, COPD, emphysema, TB exposure	
GASTROINTESTINAL:	stomach upset, diarrhea, constipation, hernia, ulcers, nausea, GERD,	
GENITOURINARY:	painful/ frequent urination, impotence, yellow jaundice, kidney stones, blood in urine	
FEMALES:	Are you pregnant? Are you nursing?	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis	
DERMATOLOGIC:	pimples, acne, warts, growths, rash, rosacea, melanoma	
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, dementia, memory loss, Alzheimer's, Parkinson's	
PSYCHIATRIC:	anxiety, depression,	
ENDOCRINE:	diabetes, hypothyroid, hyperthyroid, hormone, increased thirst, Graves Disease, Thyroid Eye Disease	
HEMATOLOGY:	bleeding, anemia, blood clots, problems related to blood transfusions,	
ALLERGIC/IMMUNOLOGIC:	sinus, sneezing, swelling, redness, itching, hives, lupus, HIV, Herpes Simplex Virus, Sjogren's Syndrome, rheumatoid arthritis,	
CANCER:	breast, prostate, lung, skin, colon, other _____	
EYES:	cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration	

List all Eye Surgeries & Laser Eye Surgeries:

List all OTHER surgeries you have had:

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition	Family Member	Disease/Condition	Family Member
Lazy Eye yes no	Mother Father Sibling Grandparent	Heart Disease yes no	Mother Father Sibling Grandparent
Macular Degeneration yes no	Mother Father Sibling Grandparent	Hypertension yes no	Mother Father Sibling Grandparent
Blindness yes no	Mother Father Sibling Grandparent	Stroke yes no	Mother Father Sibling Grandparent
Retinal Disorders yes no	Mother Father Sibling Grandparent	Thyroid Disease yes no	Mother Father Sibling Grandparent
Cataracts yes no	Mother Father Sibling Grandparent	Arthritis yes no	Mother Father Sibling Grandparent
Glaucoma yes no	Mother Father Sibling Grandparent	Cancer yes no	Mother Father Sibling Grandparent
Diabetes yes no	Mother Father Sibling Grandparent	Type of Cancer: _____	Mother Father Sibling Grandparent

MEDICAL HISTORY

JACKSON EYE ASSOCIATES

CHART# _____

Physician Signature: _____ **Date:** _____

*Richard L. Blount, MD / V. John Ford, III, MD / R. Glenn Herrington, MD / John H. McVey, MD / Robert A Mallette, MD / Robert O. May, MD
Wilson E. Moak, MD / Younghun G. Oh, MD / Philip C. Smith, MD / Kenneth P. Toler, MD / Curtis D. Whittington, MD*