

JACKSON EYE ASSOCIATES PLLC

Name: _____ Chart #: _____ Date: _____

Date of Birth: _____ Age: _____ S.S. #: _____ - _____ - _____ Height: _____ Weight: _____

Marital Status: (Single, Married, Widowed, Divorced, Separated) _____ Employed: (Yes, No, Retired, Student) _____

Conditions you have now or have had in the past, or family member (Mother-Father-Siblings-GrandParent)	Yes	No	If yes, please identify & explain condition.	Family?		Relation				
				Yes	No	M	F	S	GP	
General/Constitution (fever, heat stroke, weight loss/gain, unusually tired, HIV)										
Ears, Nose, Throat (hard of hearing, stuffy nose, earache, cough, dry mouth, sinus)										
Cardiovascular (High B/P, racing pulse, Heart attack, chest pain, Cong. Heart Failure, high Cholesterol, etc.)										
Respiratory (congestion, wheezing, short of breath, Asthma, COPD, Emphysema, etc.)										
Gastrointestinal (stomach upset, diarrhea, constipation, hernia, ulcers, GERD, etc.)										
Genital, Kidney, Bladder (painful/ frequent urination, impotence, Yellow Jaundice)										
Females: (Are you pregnant or Nursing)										
Muscles, Bones, Joints (joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid Arthritis, Lupus, etc.)										
Skin (Rosacea, pimples, warts, growths, rash, etc.)										
Neurological (numbness, headache, seizures, paralysis, stroke, Dementia, Memory Loss, etc.)										
Psychiatric (anxiety, depression, insomnia)										
Endocrine (diabetes, hypothyroid, hormone, etc.)										
Blood/Lymph (bleeding, high cholesterol, anemia, probs. related to blood transfusions)										
Allergic/Immunologic (sinus, sneezing, swelling, redness, itching, hives, lupus, rheumatoid arthritis, etc.)										
Cancer (Breast, prostate, lung, skin, colon, or other)										
EYES (Cataract, Glaucoma, Detached Retina, Blindness, Lazy Eye, Eye injury, Cornea Problems)										

Tobacco: ___ Yes ___ No ___ Seldom ___ Frequent

List any Drug Allergies:

Drugs: ___ Yes ___ No ___ Seldom ___ Frequent

Alcohol: ___ Yes ___ No ___ Seldom ___ Frequent

List any Eye or Laser surgeries you have had: _____

List any other surgeries you have had: _____

List all Prescription and over the counter medications you are taking:

ROS /Reviewed:

Medication Name and Dosage	Reason taken	Currently Taking?
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No
		Yes / No

Staff	Date

Physician signature: _____ Date: _____

All information you provide is confidential and will not be released to anyone without your consent.
Use back of form for any additional information that you need to add.