Patient Medical History

Dr. Denise Kerchner, MD
Dr. Brian Vitz, DO
Dr. Mark Grandas, OD
Dr. Jacques Surer, DO
Dr. Anna Hess, OD

This information is confidential and is for medical records only

Patient Name: _____ Date of Birth: _____SS#_____

Address where patient resides: _____

Height: _____ Weight: _____ Sex: ☐ Male ☐ Female

Phone: _____ Work/Cell: _____

E-mail: _____ Marital Status: _____

COMPLETE THIS AREA IF UNDER 18 YEARS OF AGE

Father/Guardian Name: _____ Mother/Guardian Name: _____

Address: _____ Address: _____

Phone: _____ Work/Cell: _____ Phone: _____ Work/Cell: _____

Emergency Contact Information

Emergency contact: _____ Relationship: _____ Phone: _____

Family Physician or Internist: _____ Referring Doctor: _____

Medications

Name	Dose	Times Per Day

Eye Medications

Name	Dose	RT LT

Do you take aspirin on a daily basis? ☐ YES ☐ NO

List any medications you are allergic to and the reaction:_____

Name of pharmacy: _____ Telephone: _____

Street Address: _____ City: _____ State: ___ ZIP: _____

(If your pharmacy has more than one location in the same city, please provide exact street address if known)

PLEASE CHECK ANY CONDITIONS OR ILLNESSES YOU HAVE **NOW** OR **EVER** HAD

Ear, Nose, Throat	☐ Hard of Hearing	☐ Chronic Sinus	☐ Wears Hearing Aid(s)			☐ Other
Lung Disease:	☐ Asthma	☐ Bronchitis	☐ Emphysema	☐ Sleep Apnea		☐ Other
Heart Disease/Vascular	☐ Hypertension	☐ Heart Valve	☐ Heart Attack	☐ Arrhythmia		☐ Other
GI Disease	☐ Ulcers	☐ Colitis	☐ Hepatitis	☐ Gall Stones		☐ Other
Renal/Urinary Disease	☐ Prostate	☐ Kidney Disease	☐ Bladder	☐ Kidney		☐ Other
Musculoskeletal Disease	☐ Arthritis	☐ Lupus	☐ Osteoporosis	☐ Fibromyalgia		☐ Other
Neoplastic/Cancer	☐ Type					☐ Other
Endocrine Disease	☐ Diabetes	☐ Thyroid	☐ Pituitary			☐ Other
Neurologic Disease	☐ Stroke	☐ Tumor	☐ Seizure	☐ Depression	☐ Anxiety	☐ Other
Infectious Disease	☐ Hepatitis	☐ HIV	☐ Lyme Disease	☐ Sjogren's	☐ RA/JIA	☐ Other
Blood/Lymph	☐ Anemia	☐ High Cholesterol	☐ Bleeding			☐ Other

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Childhood Developmental Illness — Please list

_____

What prior surgeries have you had?

_____

Ocular History

Active or past history of any eye conditions or disease such as glaucoma, cataracts, keratoconus, injuries or amblyopia?

_____

Prior eye surgeries including laser procedures:

_____

Do you wear glasses? ☐ Yes ☐ No If yes, how old are they? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old are they? _____

Do you know the brand of contact lenses you are wearing & where they were purchased? _____

When was your last eye exam? _____

Family Medical History

Please check any eye diseases or conditions that run in your family and indicate the relationship.

	Relationship		Relationship
☐ Glaucoma	_____	☐ Retinal Detachment	_____
☐ Cataract	_____	☐ Macular Degeneration	_____
☐ Lazy Eye	_____		

Check any other diseases or conditions that run in your family and indicate the relationship.

	Relationship		Relationship
☐ Heart	_____	☐ Neurologic	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Cancer	_____		

Is there any other information we should know about your medical history? _____

Social History

What is your occupation? _____

What are your hobbies and activities? _____

Do you smoke? ☐ YES ☐ NO If yes, how many packs per day? _____ How many years? _____

Do you consume alcohol? ☐ YES ☐ NO If yes, how many drinks per day? _____ How many years? _____

Signature: _____ Date: _____

Preferred Language: _____

Please specify your ethnicity	Please specify your race	
☐ Hispanic or Latino	☐ Asian	☐ Native American Indian
☐ Not Hispanic or Latino	☐ Black or African American	☐ White
☐ Refused	☐ Hispanic	☐ Other Race
	☐ Indian	☐ Refused
	☐ Multi-racial	