

PATIENT INFORMATION

It is IMPORTANT that you fill out ALL of the following
information and bring it to your appointment.
If it does not apply to you, simply put N/A in the space

Patient: _____ Today's Date _____

Name as it is filed with your insurance (Last, First, Middle)

Date of Birth ____/____/____ Social Security # _____

Mailing Address: _____
Please include Apt # City State Zipcode

Main Phone number _____ Alternate phone # _____

Contact Person Name: _____ Phone number _____

(If we are unable to reach you this person will be contacted) Relationship to you _____

Employer Name: _____ Phone number _____

Employer Address Address: _____
City State Zipcode

What is the name of the Doctor who referred you to our office

Phone number _____ Fax number _____

Referring Doctor's Address: _____
City State Zipcode

Your Optometrist Name: _____

(the Doctor that writes you prescription for glasses)

Phone number _____ Fax number _____

Optometrist Address : _____
City State Zipcode

Cardiologist's Name: _____

Phone number _____ Fax number _____

Cardiologist's Address : _____
City State Zipcode

Medical Doctor or Primary Care Physician: _____

Phone number _____ Fax number _____

Address : _____
City State Zipcode

PATIENT NAME _____ DATE _____

LIST ANY DRUG ALLERGIES & TYPE OF REACTION ☐ NKDA _____

LIST YOUR MEDICATIONS/SUPPLEMENTS ON ☐ REVERSE SIDE ☐ ATTACH CURRENT LIST OR CHECK ☐ NONE

ARE YOU CURRENTLY USING ANY OF THE FOLLOWING **EYE** MEDICATIONS? PLEASE CHECK:

☐ PRED FORTE 1% 1 drop _____	RT LT ☐ ☐	☐ XALATAN 0.005% 1 drop _____	RT LT ☐ ☐	☐ COSOPT 1 drop _____	RT LT ☐ ☐
☐ VIGAMOX 0.5% 1 drop _____	☐ ☐	☐ TRAVATAN 1 drop _____	☐ ☐	☐ ZYMAR 1 drop _____	☐ ☐
☐ ALPHAGAN P 0.15% 1 drop _____	☐ ☐	☐ BETOPTIC-S 0.25% 1 drop _____	☐ ☐	☐ AZOPT 1 drop _____	☐ ☐
☐ LUMIGAN 0.03% 1 drop _____	☐ ☐	☐ TIMOLOL 0.5% 1 drop _____	☐ ☐	☐ LIQUID TEARS, ETC. _____	☐ ☐

OTHER: _____

HAVE YOU EVER SUFFERED AN EYE PROBLEM REQUIRING DOCTOR'S ATTENTION? YES _____ NO _____

IF YES, EXPLAIN _____

HAVE ANY OF YOUR BLOOD RELATIVES HAD: (PLEASE CHECK YES OR NO)

BLINDNESS	Yes ☐	WHO? _____	No ☐	HEART DISEASE	Yes ☐	WHO? _____	No ☐
GLAUCOMA	☐	WHO? _____	☐	HYPERTENSION	☐	WHO? _____	☐
CATARACT	☐	WHO? _____	☐	CANCER	☐	WHO? _____	☐
DIABETES	☐	WHO? _____	☐	TYPE _____			

LIST ANY TYPE OF SURGERY THAT YOU HAVE HAD _____

CHECK CHILDHOOD DISEASES: ☐ MEASLES ☐ MUMPS ☐ CHICKENPOX ☐ OTHER _____

DO YOU HAVE MEDICAL PROBLEMS IN THE FOLLOWING AREAS? (PLEASE CHECK YES OR NO)

DIABETES TYPE 1	YES ☐	NO ☐	☐ No Insulin _____ Yrs
DIABETES TYPE 2	☐	☐	☐ Insulin _____ Yrs
			Currently: ☐ No Insulin ☐ Insulin
HEART DISEASE	☐	☐	☐ Congestive
HEART ATTACK	☐	☐	☐ Heart Failure
WHEN?	_____		
FEVER	☐	☐	
WEIGHTLOSS/GAIN	☐	☐	
EARS	☐	☐	
NOSE	☐	☐	
MOUTH / THROAT	☐	☐	
GLANDS	☐	☐	
STOMACH	☐	☐	
URINARY	☐	☐	
CANCER	☐	☐	

HIGH BLOOD PRESSURE	YES ☐	NO ☐	How long? _____
STROKE	☐	☐	Vision loss? _____
			Permanent Disability? _____
UNUSUAL BLEEDING	☐	☐	
SKIN	☐	☐	
JOINTS/BACK	☐	☐	
DIZZINESS/HEADACHE	☐	☐	
NUMBNESS	☐	☐	
DEPRESSION/ANXIETY	☐	☐	
LUNGS	☐	☐	☐ COPD ☐ Asthma
FAINTING/SEIZURES	☐	☐	
HIV / AIDS	☐	☐	
HEPATITIS	☐	☐	
OTHER	_____		

DO YOU NOW USE /OR/ HAVE YOU EVER USED: _____ TOBACCO # PACKS / DAY _____ for _____ YRS QUIT? _____
_____ ALCOHOL USE HOW MUCH/OFTEN? _____ QUIT? _____ DRUGS _____

OFFICE USE ONLY

DATE _____ MED. HX REVIEWED BY _____

JOHN A. SAURINO, DO

PATIENT NAME _____

PHARMACY	ADDRESS	PHONE NUMBER
PHARMACY NAME ↓ (1 ST Preferred)		
PHARMACY NAME ↓ (2 ND Preferred)		
PHARMACY NAME ↓ (3 RD Preferred)		
MEDICATION NAME	DOSAGE	TIMES TAKEN DAILY

***** OFFICE USE ONLY *****

MEDICAL HISTORY / MEDICATION CHANGES

DATE	CHANGES	TECH SIGNATURE DOCTOR SIGNATURE
		TECH _____ _____ JOHN A. SAURINO, DO
		TECH _____ _____ JOHN A. SAURINO, DO
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