Fillmore Eye Clinic, Inc.

1124 10th Street, Alamogordo, NM 88310
Tel. (575) 434-1200, Fax (575) 437-3947

Patient Information Sheet

Today's Date _____ / _____ / _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Child

Name _____
LAST FIRST MIDDLE INITIAL

Street Address _____ PO Box _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Date of Birth _____ / _____ / _____ Sex :☐ M ☐ F Marital Status ☐ S ☐ M ☐ W

Place of Employment _____ Occupation _____

Work Address _____

Work Phone (_____) _____ Social Security # _____ - _____ - _____

Guarantor Information (Fill out only if different from Patient Information)

Name _____ Date of Birth _____ / _____ / _____

Address _____ Phone Number (_____) _____

Relationship to Patient _____

In Case of Emergency:

Please Notify _____ At (_____) _____

Family Doctor _____ Referred by _____

DILATION: It may be necessary to dilate your eyes during the course of your eye examination or treatment. You may wish to have someone accompany you in case you are unable to drive comfortably.

REFRACTION: Refraction refers to the process of measuring the eyes for glasses. It is an essential part of any eye examination and is necessary in order to write a prescription for glasses. An additional fee will be charged for this service, which most insurance companies do NOT cover. The fee will be the patient's responsibility.

I certify that I have read and that I understand the above statements, and that I have completed the information correctly. I hereby authorize my insurance company to pay benefits directly to Fillmore Eye Clinic, Inc. I understand I am responsible for all non-covered services. I also authorize Fillmore Eye Clinic, Inc. to release any information required to my insurance company.

_____ _____
Signature Date

Fillmore Eye Clinic, Inc.

Medical History Questionnaire

Name _____ Date _____ / _____ / _____
Date of **Birth** _____ / _____ / _____ Date of **last eye exam** _____ / _____ / _____
List any **medications** you currently take (Rx and over-the-counter): _____
_____
Do you have **allergies** to any medications? ☐ YES ☐ NO
If YES, list the medications: _____
List all major **illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):
_____
List of **surgeries** yo have had (cataract, appendectomy, etc.) _____
_____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
Eyes (poor vision, eye pain, tearing, redness, etc.)			
General / Constitutional (fever, heat stroke, weight loss, weight gain, unusually tired)			
Ears, Nose, Throat (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
Cardiovascular (high blood pressure, racing pulse, etc.)			
Respiratory (congestion, wheezing, short of breath, etc.)			
Gastrointestinal (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
Genital, Kidney, Bladder (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
Females: Are you pregnant? Nursing?			
Muscles, Bones, Joints (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
Skin (pimples, warts, growths, rash, etc.)			
Neurological (numbness, headache, seizures, paralysis, etc.)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, etc.)			
Blood / Lymph (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
Allergic / Immunologic (sneezing, swelling, redness, itching, hives, lupus, etc.)			

Family History (Mother, Father, Grandparent, Siblings)
Has any member of your family had these diseases? (Check all that apply) ☐ YES ☐ NO ☐ UNKNOWN
☐ Blindness ☐ Cataract ☐ Glaucoma ☐ Diabetes ☐ Hypertension
☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Thyroid Disease ☐ Arthritis
Other heritable disease:_____

Social History
Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? ☐ YES ☐ NO
Have you ever had a blood transfusion? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO If YES, how much?_____
Do you smoke? ☐ YES ☐ NO If YES, how much?_____ How many years?_____

_____ _____
Physician's Signature Date