

Whitson Vision, PC

Patient Name: _____ DOB _____ Age _____ Date _____

Pt No. _____ Referred by: _____ PCP: _____

Medical , Family & Social History

Do you now or have you ever had any of the following? *(check all that apply)* Have you recently noticed any of the following? *(check YES or NO for each)* Y N if yes, explain

Diabetes	Change in general health			
High Blood Pressure	Ear, nose, throat problems			
Heart Disease	Chest pain, heart problems			
Lung Disease	Difficulty breathing or cough			
Chicken Pox	Joint pain / swelling			
Rubella	Skin changes / rashes			
Mumps	Headaches / weakness / numbness			
Hepatitis	Change in mood or mental health			
Polio	Thyroid / glandular problems			
Tuberculosis	Easy bruising / bleeding			
Rheumatic Fever	Stomach / bowel problems			
HIV / Aids	Lymph node enlargement			
Eye disease	Difficult / painful urination			

Please list all the doctors who currently care for you:

Doctor's Name	Address	Phone	What do you see this doctor for?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Optometrist Name: _____

Medications

Medical Problem List

Allergies

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

General Surgeries

** Continued on other side.*

Eye Medications

Eye Problem List

Eye Surgeries

Family Disease List

Do you now or have you in the past used any of the following? (*explain Yes*)

Tobacco Yes No _____
Alcohol Yes No _____
Drug Use Yes No _____

Marital Status (circle): single married divorced widow(ed)

Occupation: _____ Physician's Review _____

In order to be compliant with Medicare, Whitson Vision is moving toward electronic medical records and ePrescribing. We now have the technology available to electronically send your prescriptions to the pharmacy of your choice. This will reduce paper waste and minimize errors in filling prescriptions related to illegible hand-written orders. In order to facilitate this transition, please take a moment to provide us with your pharmacy information. *An asterisk indicates required fields.

*Patient Name: _____

*Date of Birth: _____ *Social Security Number: _____

Patient email: _____

*Pharmacy Name: _____

*Pharmacy Location: _____

Pharmacy Telephone: _____