

# Patient Update

**For faster service, please complete the following form prior to arriving at our office.**

Appointment Date \_\_\_\_\_ Single  Married  Widowed   
Patient Name (please print) \_\_\_\_\_ Birth Date \_\_\_\_\_ M or F \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cellphone \_\_\_\_\_ E-mail \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_  
Date of Last Eye Exam \_\_\_\_\_ Name of Previous Eye Doctor \_\_\_\_\_

**Personal Medical Information: Do you have problems with any of these systems?  
If yes, please check box.**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Allergic/ Immunologic | <input type="checkbox"/> Gastro Intestinal | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Blood/Lymph           | <input type="checkbox"/> Genitourinary     | <input type="checkbox"/> Nervous System  |
| <input type="checkbox"/> Cardiovascular        | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Respiratory     |
| <input type="checkbox"/> Ear/Nose/Throat       | <input type="checkbox"/> Mental            | <input type="checkbox"/> Skin Disorders  |
| <input type="checkbox"/> Endocrine (Glands)    | <input type="checkbox"/> Surgeries         |  |

If surgeries what type & when \_\_\_\_\_

Any allergic reactions to medications or other substances?  Yes  No If yes, please list below

Name of general physician \_\_\_\_\_

**Please Check: Yes or No**

Do you wear glasses?  Yes  No  
Do you wear contacts?  Yes  No Are you interested in contacts?  Yes  No  
Do you smoke?  Yes  No How much? \_\_\_\_\_  
Do you drink alcohol?  Yes  No How much? \_\_\_\_\_  
Do you take medications?  Yes  No Please list names & how often: \_\_\_\_\_

**Family History: Please check box if you or your family have had the following:**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Bloodshot Eyes      | <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Blurred Vision      | <input type="checkbox"/> Dry Eyes        | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Poor Color Vision    |
| <input type="checkbox"/> Burning Eyes        | <input type="checkbox"/> Eye Infection   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Retinal Detachment   |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Eye Injury      | <input type="checkbox"/> Itching Eyes        | <input type="checkbox"/> Seeing Halos         |
| <input type="checkbox"/> Crossed Eyes        | <input type="checkbox"/> Eye Strain      | <input type="checkbox"/> Lazy Eye            | <input type="checkbox"/> Seeing Flashes       |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Eye Surgery     | <input type="checkbox"/> Loss of Vision      | <input type="checkbox"/> Watering Eyes        |
| <input type="checkbox"/> Discharge from Eyes | <input type="checkbox"/> Floaters/ Spots |  |   |

Please explain any boxes you have checked: \_\_\_\_\_

Are you interested in laser vision correction?  Yes  No

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature X \_\_\_\_\_ Date \_\_\_\_\_

**Notice of Privacy Practices**

**EyeCare Plus  
David A. Johnson, O.D. & Nancy S. Barr, O.D.  
301-B Petrol Pt  
Peachtree City, GA 30269**

**Acknowledgement Form**

**I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.**

**Patient Name** \_\_\_\_\_ **Birthdate** \_\_\_\_\_

**Signature X** \_\_\_\_\_ **Date** \_\_\_\_\_