Date:_____

Patient Information Update

Name_____Date of birth_____

Email address_____

Home Phone_____Cell_____

Address_____

_____

Primary Care Physician_____

Please note any changes in your health since last visit_____

_____

Are you allergic to any medications? (circle one) Yes No

If yes please list_____

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EYE & LASER CENTER

REVIEW OF SYSTEMS

PATIENT INFORMATION

Name _____ Date ___/___/___

Address _____ Home Phone ___-___-____

City, State, Zip _____ Work Phone ___-___-____

Email _____ Birthdate ___/___/___

NEUROLOGICAL	Yes	No
Headaches	○	○
Migraines	○	○
Seizures	○	○
EYES		
Loss of Vision	○	○
Blurred Vision	○	○
Distorted Vision / Halos	○	○
Loss of Side Vision	○	○
Double Vision	○	○
Dryness	○	○
Mucous Discharge	○	○
Redness	○	○
Sandy/Gritty Feeling	○	○
Itching	○	○
Burning	○	○
Foreign Body Sensation	○	○
Excess Tearing	○	○
Glare/Light Sensitivity	○	○
Eye Pair on Soreness	○	○
Chronic Infections	○	○
Flashes / Floaters	○	○
Tired Eyes	○	○

ENDOCRINE	Yes	No
Thyroid	○	○
Lymphatic/Hematologic		
Anemia	○	○
EARS, NOSE, MOUTH, THROAT		
Allergies	○	○
Sinus Congestion	○	○
Runny Nose	○	○
Post-Nasal Drip	○	○
Chronic Cough	○	○
Dry Throat/Mouth	○	○
RESPIRATORY		
Asthma	○	○
Chronic Bronchitis	○	○
Emphysema	○	○
VASCULAR/CARDIOVASCULAR		
Diabetes	○	○
Heart Pain	○	○
High Blood Pressure	○	○
GASTROINTESTINAL		
Constipation	○	○
GENITOURINARY		
Genital/Kidney/Bladder	○	○

If you answered YES to any of the above or have a condition not listed, please explain and list medications _____

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HIPAA – NOTICE OF PRIVACY PRACTICES

Patient _____ DOB: ___/___/___ Date: ___/___/___

I hereby acknowledge that I received Behler Eye and Laser Center's Notice of Privacy Pracices.

_____ _____

Patient Signature Date

I may be contacted by phone in the following manner (check all that apply):

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

- ☐ Please leave a detailed message
- ☐ Please leave a call back number only
- ☐ Please leave a message with my:
  - ☐ Spouse: _____
  - ☐ Caregiver: _____
  - ☐ Adult Children: _____
  - ☐ Other: _____

Persons who may receive information about my care are: _____

_____

_____

Additional HIPAA compliance notification information is available at your request

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Name:_____ Date of Birth_____

Current Eye Medications: (Please list)

□ None

_____ _____ _____

_____ _____ _____

All Other Medications: (Please list and include any aspirin or vitamins)

□ None

Medication name	Dose	Directions	Reason for taking	Prescriber name

Patient/Parent or Guardian Signature_____ Date_____