THE WITLIN CENTER

FOR ADVANCED EYECARE

Last Name:	**First Name:**
Birthday:	**Social Security #:**

Home Street Address:	**Town and Zip Code:**
Cell Phone #	**Home Phone #**

Pharmacy Name:	**Pharmacy Address (Town):**
Pharmacy Phone #:	

Family Physician (PCP) Name:	**Family Physician (PCP) Phone #:**
Referring Physician Name:	**Referring Physician Phone #**

Emergency Contact Name:	**Emergency Contact Phone #**
HIPAA Approved Contact Name:	**HIPAA Contact Phone #**
HIPAA Contact Relation:	

Patient Signature:	**Signature Date:**

Date:_____

Name:_____ **Date of birth:**_____

Reason for today's visit:_____

Do you smoke? Yes No Occasionally **Drink Alcohol?** Yes No Occasionally

Please list the names & dosage of any/all medications, eye drops and/or vitamins you take on a daily basis: Include any blood thinners (ie: aspirin/ coumadin/ aleve etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list all allergies to food/ medications/ latex:

_____ _____ _____

Check any of the following conditions that apply to you:

___High blood pressure
___Stroke
___Respiratory
___Thyroid
___Heart
___Tuberculosis
___Kidney
___Prostate
___Anxiety
___Cancer
___Depression
___Hepatitis
___Cough
___Cholesterol
___HIV/ AIDS
___Gastrointestinal
___Blood abnormalities
___Diabetes(circle): Type 1 Type 2
___Fatigue
___Autoimmune
___Neurological
___Psychiatric

Last A1C_____ Last BS_____ Fasting/ Not

Eye Conditions: ___Cataracts ___Glaucoma ___Macular Degeneration ___Dry Eye

Any other eye/ medical conditions not mentioned above:_____

_____

_____

Surgery History:_____

_____

_____

Eye Surgery History:_____

_____

_____

Family Medical History: _____

_____

_____

Family Eye History: _____

_____

_____

_____