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

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Eye Problem List

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Eye Surgeries

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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 Insurance Policies, 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: _____