GLENDORA
210 S. Grand Ave, ste 106
Glendora, CA 91741

Pasadena
2619 E. Colorado Blvd, ste 100
Pasadena, CA 91107

FOOTHILL EYE CARE

PATIENT INFORMATION FORM

West Covina
1135 S. Sunset Ave, ste 304
West Covina, CA 91790

Montebello
229 E. Beverly Blvd
Montebello, CA 90640

Last Name:	First Name:	Middle Intial:	Date of Birth:
Address:	City:	State:	Zip:
SS#:	Home Phone:	Cell Phone:	Work Phone:
Sex: {M} {F}	Marital Status:	Preferred Contact Information:	
Perferred Language:	E-mail:		
Occupation:	Employer:	Employer Phone:	

Referring Doctors

Referring Doctor:	Address:	Phone/Fax:
Primary Care Doctor:	Address:	Phone/Fax:

Insurance & Pharmacy Information

Primary Insurance:	ID # :
Secondary Insurance:	ID # :

Main Subscriber:	SS#:	DOB:

Financially Responsible Party (if different from above)

Name:	Address:	Phone:
Relationship:	SS#:	DOB:

Pharmacy Information

Pharmacy:	Address:	Phone:

IN CASE OF EMERGENCY

Emergency Contact:	Relationship:	Home/Cell:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Foothill Eye Care Services or insurance company to release any information required to process my claims.

Patient/Guardian Signature **Date**

Print Name **Relationship**

FOOTHILL EYE CARE

PATIENT INFORMATION FORM

Name:	DOB:	Referring Doctor:
Right Eye / Left Eye / Both Eye	What problem are you here for today?	
When Did It Start?	Was that onset: SUDDEN / GRADUAL / INTERMITTENT	
Do you have any pain? YES / NO	Which part of your vision has changed? CENTRAL / RIGHT / LEFT / TOP / BOTTOM	
Do you have: FLASHES OR FLOATERS?	Is your vision: BLURRY / HAZY / CLOUDY	
Is it getting: BETTER / WORSE / STAYING THE SAME	Date of your last eye exam? _____	

Have you had any EYE PROBLEMS / TREATMENTS in the PAST? YES / NO (If Yes, Please List)

PAST EYE PROBLEMS	Right Eye	Left Eye	Laser or Injection, Date?	Surgery, Date?
Macular Degeneration				
Retinal Detachment / Tear				
Diabetic Retinopathy				
Other Retina Problem				
Glaucoma				
Cataract Surgery				
Other				

Do you use any eye drops? YES / NO (If YES, Please List)

Right Eye	**Left Eye**

Family History of Eye Disease? YES / NO (If YES, Please List)

Cataract / Glaucoma / Macular Degeneration / Dystrophy / Retinal Detachment / Retinal Tear / Hereditary Retinal Degeneration / Uveitis Any other eye conditions (please specify) _____

Your Medical and Surgical History

Do you have any medical conditions for which you are treated? YES / NO Are you pregnant? YES / NO

Have you had any significant surgeries? (If YES, Please List)

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PATIENT INFORMATION FORM

Do you use any systemic medications? YES / NO (If YES, Please List)

Allergies

Do you have allergies to any foods or medications? YES / NO

Do you have any allergy to iodine? YES / NO

Do you have any allergy to sulfa? YES / NO

If yes, please also list reactions:

Family Medical History (If YES, Please List)

Autoimmune / Blood Disease / Cancer / Diabetes / GI Tract / Heart Disease / Hypertnesion / Kidney Disease / Psychiatric / Respiratory / Other _____

Review of System (ROS)

Have you had any of these problems?	**If yes, please explain**
Chronic Fever, Unexplained Weight Loss, Night Sweats	
Caridovascular (chest pain, irregular heart beat)	
Endocrine (excessive urination, heat or cold intolerance)	
Gastrointestinal (heart burn, abdominal pain, nausea, diarrehea)	
Genitourinary (pain on urination, dialysis, bladder infections)	
Oncology / Hematology (easy bruising, prolonged bleeding)	
Ear / Nose / Throat (hearing loss,runny nose, sore throat)	
Dermatological (rash, skin cancer, eczema, dermatisis)	
Musculoskeletal (joint pain, muscle aches)	
Neurologic (weakness, headaches, stroke, numbness/tingling)	
Respiratory (asthma, wheezing, cough, shortness of breath)	
Psychiatric (depression, anxiety)	

Social History

Martial Status	Married / Single / Divorced / Widowed / Separated / Partner
Smoking	Never / Former smoker stopped _____ yr / Current smoker _____/pack day
Alcohol	None / Occasional/Social / 1-2 Drinks/day / 3-4 Drinks/day

Dilation Authorization

Dilating drops are used to dilate/enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilation may cause blur vision and sensitivty to light for a length of time, which may be slightly bothersome. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremly rare and treatable with immediate medical attention. The eye drops are necessary to diagnose my condition. I hereby authorization a medical professional at Foothill Eyecare Services to administer dilating eye drops.

_____ _____

Patient/ Guardian signature **Date**

_____

Print Name