SPADAFORA & ZAK
NEIGHBORHOOD EYE CARE

Patient Information

Today's Date: _____
Last Name: _____
First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Cell Phone: _____
Gender: M F Date of Birth: _____ Age: _____
Patient SSN: _____
Marital Status: _____
Employer: _____
Occupation: _____
Email: _____
Texting Ok? ☐ Yes ☐ No

Vision Insurance:
☐ VSP ☐ EyeMed ☐ Other: _____

Medical Insurance:
☐ BCBS ☐ Medicare ☐ Priority Health ☐ Aetna ☐ Cigna
☐ Cofinity ☐ Other: _____

Privacy Practices for Health Information

NOTICE OF PRIVACY PRACTICES: I have been offered a copy of Spadafora & Zak's statement and HIPPA consent on privacy practices.

AUTHORIZATION TO RELIEASE INFORMATION: I authorize Spadafora & Zak Eyecare to release any information including diagnosis, records of treatment, or examinations rendered to me or my child during the period of such eye care to 3rd party payers and/or health practitioners.

CONSENT FOR TREATMENT: I hereby grant my authorization and consent for medical treatment and procedures for myself and/or minor children as may be necessary for proper health care.

_____ _____
Patient Signature Date

Patient Medical History

Primary Physician: _____
Location: _____ Phone: _____
Date of Last Physical: _____
Pharmacy: _____ Phone: _____
Location of Pharmacy: _____

REVIEW OF SYSTEMS

Have you every been diagnosed for the following health problems?

Constitution
- ☐ Cancer
- ☐ Fatigue Syndrome

ENT
- ☐ Sinusitis
- ☐ Dry Mouth

Neuro
- ☐ Multiple Sclerosis
- ☐ Stroke / CVA
- ☐ Migraine

Psychiatric
- ☐ Depression
- ☐ Anxiety Disorder

Cardiovasc
- ☐ Hypertension
- ☐ Heart Disease

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea

Gastrointestinal
- ☐ Crohn's
- ☐ Ulcer
- ☐ Acid Reflux

Genitourinary
- ☐ Kidney Disease
- ☐ Prostate Cancer

Musculoskeletal
- ☐ Arthritis
- ☐ Ankylosing Spondylitis

Integumentary (skin)
- ☐ Eczema
- ☐ Rosacea

Endocrine
- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Thyroid Dysfunction

Hematologic/Lymphatic
- ☐ Anemia
- ☐ High Cholesterol

Allergic/Immunologic
- ☐ Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus

CURRENT MEDICATIONS (Rx or Over the Counter)

(List the name of medications including eye drips & vitamins)

_____
_____

Allergies to medications? ☐ YES ☐ NO
If so, what medications? _____
_____

Have you had any surgeries? ☐ YES ☐ NO
If so, please describe: _____
_____

Are you pregnant or nursing? ☐ YES ☐ NO

Do you use: ☐ Tobacco ☐ Alcohol ☐ Other
If so, how often: _____

Patient Eye History

Date of Last Eye Exam: _____
Previous Eye Doctor: _____

EYE CONDITIONS

Have you been diagnosed with any of the following?
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Diabetic Retinopathy
- ☐ Dry Eye
- ☐ Retinal Detachment
- ☐ Amblyopia (lazy eye)
- ☐ Strabismus (eye turn)

Are you currently experiencing any of the following problems?

EYE CONCERNS
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Tearing
- ☐ Discharge

VISION CONCERNS
- ☐ Blurry Vision without glasses/CLs
- ☐ Blurry Vision with glasses/CLs
- ☐ Eyestrain
- ☐ Eye Pain
- ☐ Severe light sensitivity
- ☐ Headache
- ☐ Double Vision
- ☐ Loss of Vision
- ☐ Flashes / Floaters

Family Medical/Eye History

Please note any family history (parents, grandparents, siblings, children) for the following conditions:

	Which family member?
Cancer	☐_____
Type 1 Diabetes	☐_____
Type 2 Diabetes	☐_____
Hypertension	☐_____
Glaucoma	☐_____
Cataract	☐_____
Macular Degeneration	☐_____
Retinal Problems	☐_____