WELCOME TO THE OFFICE OF:

ALDRIDGE EYE INSTITUTE, O.D., P.A.

Mr.
Ms.
Name: Mrs. _____ Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home#: _____ Cell#: _____ Email: _____

Age: _____ Birth Date: _____ Social Security Number: _____

Race: _____ Language: _____ Ethnicity: _____

Occupation: _____ Employer: _____ Work#: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

If minor, responsible party: _____

☐ If completed by someone other than patient; Signature: _____ Relationship: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

Reason for your visit today (be specific)? _____ Referred by: _____

Please review and check the following complaints you have:

☐ Headaches
☐ Double Vision
☐ Eye Pain or Discomfort
☐ Blurred Vision (Far, Near or Both?) _____
☐ Poor Depth Judgment
☐ Floaters/Flashes of Light

Other: _____

Do you **CURRENTLY** have any problems in the following areas? If **YES**, please provide information.

	YES	NO	EXPLANATION OF PROBLEM
EARS, NOSE, THROAT (Sinus, Ear Infection, Chronic Cough, Dry Mouth, etc.)			
CARDIOVASCULAR (Heart, Vessels, etc.)			
RESPIRATORY (Asthma, Emphysema, etc.)			
GASTROINTESTINAL (Stomach Ulcers, Intestinal Disease, Hepatitis, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, Warts, Skin Cancer, etc.)			
NEUROLOGICAL (Multiple Sclerosis, etc.)			
PSYCHIATRIC (Anxiety, Depression, Insomnia)			
ENDOCRINE (Diabetes, Hypothyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, Anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay Fever, Lupus, Sjogens, HIV, Aids, seasonal allergies, etc.)			
GENERAL (Fever, Weight Loss, Other)			

MEDICATIONS

List all medications that you currently take, including eye drops, over the counter medications, vitamins or supplements:

How do you wish to pay for today's visit?

☐ Check/Cash/Credit Card ☐ Vision Insurance ☐ Medical Insurance **(Please Present ALL Insurance Cards)**