Dr. Allen D. Hoek, O.D. **PATIENT INFORMATION** **Date: _____**

Name:_____ Home Phone: (____) _____

Address: _____ Cell Phone: (____) _____

City:_____ State: _____ ZIP:_____ Sex: ☐ M ☐ F Birthdate: ___/___/_____

Employer: _____ Business Phone: _____

Spouse's Name: _____ Last 4 numbers of Soc. Sec #: _____

Emergency Contact: _____ Emergency Phone #: _____

Relationship to patient:_____ Primary Care Physician: _____

Race: American Indian / Asian / African American / Caucasian / Hawaiian / Hispanic / Latino / Middle Eastern / Pacific Island
Language: English / Spanish / Cantonese / Mandarin / Other: _____
Preferred Method of Communication: Email / Postal / Telephone / Text Message

Email: _____

Please list current medications you are taking (including over-the-counter eye drops, vitamins or supplements, aspirin and oral contraceptives): _____
_____

Are you allergic to any medications? ☐ No ☐ Yes (describe) _____
_____

List any major injuries, surgeries and/or hospitalizations you have had and dates: _____
_____

Have you had any of the following: ☐ None

☐ Crossed eyes	☐ Lazy eye	☐ Drooping eyelid	☐ Eye infection
☐ Cataract	☐ Eye Surgery	☐ Macular degeneration	☐ Glaucoma

Do you wear ☐ glasses ☐ contact lenses
Type of contacts: ☐ Rigid ☐Soft ☐ Extended Wear ☐Other Are they comfortable? ☐ Yes ☐ No
How often do you replace your contact lenses? ☐ Daily ☐1-2 weeks ☐ Monthly ☐Other _____
What brand of contact lenses do you wear? _____

Insurance coverage:
Do you have vision insurance? ☐ Yes ☐ No If yes, name of insurance: _____
Name of insured Member: _____ Date of Birth:_____
Last 4 numbers of Member's Social Security #: _____

_____ _____
Signature of Patient, Parent, Guardian or Person Responsible for Payment Date

Have you, the patient, ever experienced any problems in the following areas?

System Constitutional	No	Yes
Fever/Weight loss/Gain	N	Y
Integumentary		
Eczema	N	Y
Psoriasis	N	Y
Cancer	N	Y
Neurological		
Headaches	N	Y
Migraines	N	Y
Seizures	N	Y
Multiple Sclerosis	N	Y
Cancer	N	Y
Ear/Nose/Throat		
Allergies/Hay Fever	N	Y
Sinus Congestion	N	Y
Chronic Cough	N	Y
Dry Throat/Mouth	N	Y

Endocrine	No	Yes
Non-insulin Dependent Diabetes	N	Y
Insulin Dependent Diabetes	N	Y
Thyroid Dysfunction	N	Y
Hormonal Dysfunction	N	Y
Respiratory		
Asthma	N	Y
Chronic Bronchitis	N	Y
Emphysema	N	Y
Cancer	N	Y
Vascular/Cardoivascular		
High Blood Pressure	N	Y
High Cholesterol	N	Y
Stroke	N	Y
Heart Disease	N	Y
Lymphatic/Hematological		
Bleeding Problems	N	Y

Gastrointestinal	No	Yes
Crohn's	N	Y
Colitis	N	Y
Ulcer	N	Y
Digestive	N	Y
Genitourinary		
Genitals/Kidney/Bladder		
Allergy/Immunological		
Drug Allergy	N	Y
Environmental Allergy	N	Y
Rheumatoid Arthritis	N	Y
Lupus	N	Y
Psychiatric		
Depression	N	Y
Panic Disorder	N	Y
Schizophrenia	N	Y
Are you currently Pregnant or Nursing	N	Y

Your Eye Symptoms – Do you (patient) experience any of the following?

Blurred Vision	N	Y	Dry Eyes	N	Y	Night Vision Problems	N	Y
Distorted Vision	N	Y	Gritty/Sandy Eyes	N	Y	Floating Spots	N	Y
Losing Place While Reading	N	Y	Red Eyes	N	Y	Flashing Lights	N	Y
Double Vision	N	Y	Extreme Light Sensitivity	N	Y	Dizziness	N	Y
Watery Eyes	N	Y	Depth Perception Problem	N	Y	Discharge From Eyes	N	Y
Itchy Eyes	N	Y	Color Vision Difficulties	N	Y	Other:		
Burning Eyes	N	Y	Seeing Rings Around Lights	N	Y			

Family History: Has anyone in the patient's family (blood relative) had any of the following?

Cataracts	N	Y	Glaucoma	N	Y	Heart Disease	N	Y
Cornea Disease	N	Y	Lazy Eye	N	Y	Diabetes	N	Y
Crossed Eyes	N	Y	Macular Degeneration	N	Y	High Blood Pressure	N	Y
Retina Disease	N	Y	Cancer	N	Y	Other:		

Social History: ***This information is kept confidential. However, you may discuss this portion directly with Dr. Hoek, if you prefer.***

☐ Yes, I would prefer to discuss my Social History information directly with Dr. Hoek.

Occupation: _____

Do you use tobacco? ☐ No ☐ Yes If yes, type/amount/how long? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long? _____

Patient Signature	Date:
Name of Person Completing Form (if not patient)	Relationship to Patient