

Patient Information		Today's Date:	
Last:		First:	Middle:
Date of Birth:		Occupation:	Sex:
Address:			Height:
City, State, Zip:			Weight:
Our preferred method of communication with you will be your cell phone. By signing below, I consent to receive text messages from Havasu Eye Center. These messages will only be a reminder of an upcoming appointment or a reminder to schedule an appointment. Signature:		Patient Cell #: Parent/Guardian Cell #: Home Phone #:	
Email Address:		Social Security #:	
Parent/Guardian Name and Date of Birth: _____ / _____ / _____			
Emergency Contact Name:		Relation:	
Emergency Contact Phone #:		Primary Care Physician:	
Ethnicity:		Language:	
Does anyone in your family have the following:			
<input type="checkbox"/> Blindness	<input type="checkbox"/> Cataracts	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Cancer	
<input type="checkbox"/> Lazy Eye	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	
Have you had any eye surgeries?	Yes No	Type and Date:	
Have you had any eye injuries?	Yes No	Type and Date:	
Do you wear contact lenses?	Yes No	Type:	
Current Medications:			

Medical Allergies: _____			

Please Proceed to the Next Page

<p>Allergic/Immunologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Drug allergy <input type="checkbox"/> Environmental allergy <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Other: _____ 	<p>Eyes</p> <ul style="list-style-type: none"> <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Surgery <input type="checkbox"/> Inflammatory disorders <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Other: _____ 	<p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Other: _____ 	<p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Vascular disease <input type="checkbox"/> Heart attack <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____
<p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Ulcer <input type="checkbox"/> Digestive <input type="checkbox"/> Other: _____ 	<p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Parkinson's <input type="checkbox"/> Cerebrovascular <input type="checkbox"/> Other: _____ 	<p>Constitutional</p> <ul style="list-style-type: none"> <input type="checkbox"/> Developmental disability <input type="checkbox"/> Weight loss <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Trauma <input type="checkbox"/> Other: _____ 	<p>Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> STD <input type="checkbox"/> Viral herpetic <input type="checkbox"/> Chlamydia <input type="checkbox"/> Other: _____
<p>Psychiatric</p> <ul style="list-style-type: none"> <input type="checkbox"/> Depression <input type="checkbox"/> Panic disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other: _____ 	<p>Ear, Nose, Mouth & Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> Upper respiratorytract infection <input type="checkbox"/> Ear ache <input type="checkbox"/> Runny nose <input type="checkbox"/> Sore throat <input type="checkbox"/> Ringing/Tinnitus <input type="checkbox"/> Other: _____ 	<p>Hematologic/Lymphatic</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Large volume blood loss <input type="checkbox"/> Leukemia <input type="checkbox"/> Other: _____ 	<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Smoking Status <ul style="list-style-type: none"> <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Other: _____
<p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Non-insulin dependent diabetes Year diagnosed: _____ <input type="checkbox"/> Insulin-dependent diabetes <input type="checkbox"/> Thyroid dysfunction <input type="checkbox"/> Hormonal dysfunction <input type="checkbox"/> Other: _____ 	<p>Integumentary (Skin)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other: _____ 	<p>Cancer</p> <ul style="list-style-type: none"> <input type="checkbox"/> Type: _____ <input type="checkbox"/> Year: _____ 	<p><input type="checkbox"/> I have no medical conditions I am aware of</p> <hr/> <p>Signature</p> <hr/> <p>Date</p> <hr/>