Richard Sterling OD & Associates

Patient Information

Today's Date: _______/________/_________

Name: ____

Address: ____

City/State/Zip: ____

Home Phone: _______________________

Work Phone: _______________________

Cell Phone: _______________________

E-Mail Address: ____

**Dr. Sterling's office increasingly uses email to communicate with and educate patients.
The office will keep your email confidential and will not sell or distribute your email to any third parties.

Birth Date: ____ / ____ / _____ Social Security #: _____ /____ / ______

Occupation: _______________________

Medical Doctor: __________________ Dr.'s Phone Number:_______________

Chief reason for visit today: _________________________________

How did you hear about us? ______________

Last Medical Exam:_____ / _____ / _____ Last Eye Exam: _____/______/_____

Health Insurance Co: ________________ ID: ________________________

Vision Insurance: ___________________ ID: _________________________

As a courtesy to you, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

I understand that I am responsible for payments of services rendered, including deductibles and co-payment/co-insurance, and services not covered by my insurance as determined by my contract with the insurance carrier.

Signed:___________________________________ Date: __________________________

Richard Sterling OD & Associates

Name: ______________________________ Today's Date: _____/_______/________

Medical Information

Do you have any allergies to medications? ☐ No ☐ Yes If yes, explain: ______________________

List any medications you take (include oral contraceptives, aspirin, over the counter medications, supplements and home remedies)

____

List all major injuries, surgeries and/or hospitalizations you have had in the past 5 years: ______________________

____

Do you currently have any problems with any of these systems? (Please circle yes or no)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/immunologic	Yes/No
Respiratory	Yes/No	Skin (integumentary)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

If you answered yes to any of the above, please explain: ______________________

____

Are you pregnant or nursing? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes If yes, how frequently? ______________________

Family History

High Blood Pressure	Yes/No	Relation__________	Macular Degeneration	Yes/No	Relation__________
Diabetes	Yes/No	Relation__________	Retinal Detachment	Yes/No	Relation__________
Glaucoma	Yes/No	Relation__________	Cataracts	Yes/No	Relation__________
Cancer	Yes/No	Relation__________	Arthritis	Yes/No	Relation__________
Heart Disease	Yes/No	Relation__________	Other	Yes/No	Relation__________

Personal Eye Information

Do you have any eye conditions or problems? Yes/ No What kind? ______________________

Have you had any eye operations? Yes/No Type ______________________ Date __________

Have you had an eye injury? Yes/No Kind ______________________ Date __________

Do you have Glaucoma?	Yes/No	Cataracts?	Yes/No	Dry Eyes?	Yes/No
Macular Degeneration?	Yes/No	Retinal Detachment?	Yes/No	Blurred or disorted Vision?	Yes/No
Light/Glare sensitivity?	Yes/No	Eye Pain or Soreness?	Yes/No	Infection of eye or lid?	Yes/No
Stye or Chalazion?	Yes/No	Flashers or Floaters?	Yes/No	Foreign body sensation?	Yes/No
Itching or burning?	Yes/No	Excess tearing or watering?	Yes/No	Redness?	Yes/No

Do you wear glasses? Yes/No If yes, how old is your present pair of lenses?

Do you wear contacts lenses? Yes/No If yes, how old is you present pair of lenses?

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ Yes ☐ No

Do you know the brand of contact lenses that you wear? ______________________

Do you drive? ☐ No ☐ Yes

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor (check box)

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Doctor's Signature: ______________________ Date: _____/_______/_______