WELCOME TO OUR OFFICE

Patient Information

(Please fill out all available spaces)

Dr. DAVID W. BANG
OPTOMETRIST

Date:_____

Last:_____ First:_____ MI:____ Male / Female

Street:_____ Apt._____ City:_____ State:_____ Zip Code:_____

Home Ph:_____ Work Ph:_____ Cell:_____ Email:_____

Patient's SSN:___-___-_____ Date of Birth:____/____/____ Age:_____ Height:_____ Weight:_____

Employer or School:_____ Occupation or Grade:_____ Marital Status: Married ____
Single ____
Divorced ____
Widowed ____
Separated ____

Spouse or Parent's Name:_____

What is the purpose of your visit today?_____

COVID-19

Have you been in contact with someone who tested positive for COVID-19? ( )Yes ( )No

Have you received a full vaccine for COVID-19? ( )Yes ( )No

Have you had any of these symptoms within the last 2 weeks? ( )Yes ( )No
(Please mark any that apply)

- ○ Fever
- ○ Cough
- ○ Fatigue
- ○ Nausea/Vomiting
- ○ Loss of Taste/Smell
- ○ Onset Headache/Sore Throat
- ○ Traveled in the last 2 weeks
- ○ Been Advised to Quarantine
- ○ Been Tested for COVID-19 - Results/Date_____

Vision Insurance: _____
Subscriber Name:_____
Subscriber SSN:___-___-_____
Subscriber Birth Date:____/____/____

Primary Medical Insurance: _____
Subscriber Name:_____
Subscriber SSN:___-___-_____
Subscriber Birth Date:____/____/____

*Primary care physician:*_____
Clinic Name:_____
Date of last health exam:_____
Last Eye exam:_____

Current Medications (RX or over the counter)
(List the name of the *medications* including *eye drops, birth control, vitamins*)

_____

_____

_____

If you have been diagnosed or treating any of the following please indicate them below. (please mark any that apply to you and blood related family members)

	Self	Family		Self	Family
Allergies	___	___	Eczema/Rashes	___	___
Arthritis	___	___	Fatigue	___	___
Blood/Lymph	___	___	Fevers	___	___
Bronchitis	___	___	Genitourinary	___	___
Cancer	___	___	High Blood Pressure	___	___
Cholesterol	___	___	Integumentary (skin)	___	___
Diabetes	___	___	Kidney	___	___
Digestive	___	___	Muscle/Bone	___	___
Ears/Nose/Throat	___	___	Neurological	___	___
Endocrine	___	___	Psychological	___	___
Respiratory	___	___	Sinus	___	___
Throat Infections	___	___	Thyroid	___	___

Other_____

Allergies to Medications? ( )Yes ( )No
If so, what medications?_____
_____

Have you had any surgeries? ( )Yes ( )No
If yes, please list _____

Do you drink alcohol? ( )Yes ( )No
If yes, how much/often? _____

Do you smoke? ( )Yes ( )No
If yes, how much/often? _____

Do you use any other substances'? ( )Yes ( )No
If yes, please list _____

Have you ever had a blood transfusion performed? ( )Yes ( )No

Have you ever been treated for a STD (i.e., herpes, HIV, AIDS, etc.)? ( )Yes ( )No
If yes, please list _____