EISEL VISION CLINIC: PATIENT UPDATE FORM

Please fill out this form and bring it in prior to or same day as your eye examination.

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

SS #: ______________________________

Marital Status: ______________________________

Birth Date: ______________________________

Sex: ______________________________

Home Phone: __________ **Cell Phone:** __________ **Work Phone:** __________

Primary Ins: ______________________________

Insurance ID #: ______________________________

____

Please answer the following questions.

What is your occupation? ______________________________

Who is your primary care physician? ______________________________

Please list all your current medications. ______________________________

____

Please list all your health problems. ______________________________

____

If you have diabetes, what and when was your last blood sugar, and what was your last A1c?

____

Please list any allergies (environmental or medication) that you have. ______________________________

____

The following questions are required for a comprehensive office visit.

Do you smoke? _____________ **Did you ever smoke?** _____________

Do you average more than 1-2 drinks of alcohol per day? ______________________________

Are you taking any other chemicals?

____