BLAHNIK EYE CARE

Patient Information (Please Print)

Miss Mrs. Ms. Mr. Dr. (Please Circle) Email address_____

Last Name_____ First Name_____ MI_____ Male Female

Social Security Number_____ Needed for insurance Married YES or NO

Address_____ Zip Code_____

Home Phone:_____ Business Phone: _____ Cell:_____

DOB____/____/____ Occupation_____ Employer_____

Emergency Contact_____ Phone #:_____

Date of last exam_____ Dilated? YES / NO Referred By:_____

Have you seen Dr Blahnik before? YES NO

Vision Insurance_____ Medical Insurance_____

Medical Information **Vitals Height_____ Weight_____**

What is your general health_____ ARE YOU PREGNANT YES OR NO

Do you have 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/Lym/cholesterol**	Yes/No
Cardiovascular	Yes/No	**Muscles/Bones**	Yes/No	**Allergic/Immunologic**	Yes/No
Respiratory	Yes/No	**Integumentary(skin)**	Yes/No	**Headaches**	Yes/No
High Blood Pressure	Yes/No	**Thyroid**	Yes/No	**Mental**	Yes/No

Please explain any yes above_____

Diabetes Yes/No Type_____ Date of Diagnosis_____

Allergies to Medication Yes/No Which?_____ Reaction_____

Current Medications:_____

Name of family doctor_____

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_____		

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_____

Do you have Glaucoma Yes/No Drops using for Glaucoma_____

Cataracts	Yes/No	Dry Eyes	Yes/No	Macular Degeneration	Yes/No
Retinal Detachment	Yes/No	Blurred Vision	Yes/No		
Do you wear glasses?	Yes/No	Contact Lenses	Yes/No	Type_____	

Additional Information_____

Social History:

Y N Do you drink alcohol? How may drinks per day? _____

Y N Do you smoke? Every Day____ Some Day_____ Cigarettes or Cigars

Y N Have you ever smoked before? If yes when did you quit _____

Demographics:

__African American ___American Indian ___Arab ___Caucasian

__Hawaiian ___Hispanic/Latino ___Indian ___Indian ___Multi Racial

Preferred Language; ____English _____Other, please specify_____

I understand that many examinations will require dilation of the pupil of the eye, which may make my driving vision blurry and light sensitive, and my transportation is my responsibility.

_____ Date:____/____/____

Signature

SEE ADDITIONAL PAGES PLEASE