Shoji Morita, OD
Kenneth L. Weiner, OD

Patient History Form

Last name__________________ First name________________ MI ____ Date______________
Date of Birth________________ Gender: M / F Social Security Number: ________________________
Address: ____City:____________________State:____Zip:________
Phone: (H) _________________________ (Work) _________________________ (Cell) ________________________
Vision Insurance: ___________________________________Medical Insurance: ________________________________
Family Doctor: ______________________________________Family Doctor's Phone: ____________________________
Occupation: _____________________________Hobbies: ____
Ethnicity: ________________________________Preferred Language: ______________________________________
Who referred you to us? Email:

PERSONAL AND FAMILY MEDICAL AND EYE HISTORY

Do you or any member of your family have any problems in the following areas? (Y=Yes, N=No)

	Self		Family			Self		Family	
Glaucoma	☐ Y	☐ N	☐ Y	☐ N	Diabetes	☐ Y	☐ N	☐ Y	☐ N
Cataracts	☐ Y	☐ N	☐ Y	☐ N	High Cholesterol	☐ Y	☐ N	☐ Y	☐ N
Macular Degeneration	☐ Y	☐ N	☐ Y	☐ N	Smoking	☐ Y	☐ N	☐ Y	☐ N
Cancer	☐ Y	☐ N	☐ Y	☐ N	Alcohol Abuse	☐ Y	☐ N	☐ Y	☐ N
Surgery	☐ Y	☐ N	☐ Y	☐ N	Substance Abuse	☐ Y	☐ N	☐ Y	☐ N
High Blood Pressure	☐ Y	☐ N	☐ Y	☐ N	Are you Pregnant	☐ Y	☐ N		

Genitourinary (E.g. STD, Viral Herpetic, Chlamydia)	☐ Y	☐ N	Gastrointestinal (E.g. Crohn's, Colitis, Ulcer, Digestive)	☐ Y	☐ N
Neurological (E.g. Multiple Sclerosis, Epilepsy, Alzheimers,Parkinsons)	☐ Y	☐ N	Eyes (E.g. Surgery, Blurred Vision, Double Vision)	☐ Y	☐ N
Ear,Nose,Mouth,Throat (E.g. URT Infection, Ear Ache, Ringing/Tinitis)	☐ Y	☐ N	Cardiovascular (E.g. Heart Disease, Hypertension, Stroke)	☐ Y	☐ N
Integumentary (E.g. Eczema, Rosacea, Psoriasis)	☐ Y	☐ N	Musculoskeletal (E.g. Fibromyalgia, Muscular Dystrophy,Osteoarthritis)	☐ Y	☐ N
Respiratory (E.g. Asthma, Bronchitis, Emphysema)	☐ Y	☐ N	Psychiatric (E.g. Depression, Panic Disorder, Schizophrenia)	☐ Y	☐ N
Hematologic/Lymphatic (E.g. Anemia, Large blood loss, Leukemia)	☐ Y	☐ N	Endocrine (E.g. Diabetes, Thyroid Dysfunction)	☐ Y	☐ N
Constitutional (E.g. Disability, Weight Loss, Fever, Fatigue, Trauma)	☐ Y	☐ N	Allergic/Immunologic (E.g. Rheumatoid Arthritis, Lupus)	☐ Y	☐ N

Please list all medications that you are currently taking including over the counter: None ☐

____

Please list allergies to all prescription and non-prescription medications and what happens: None ☐

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ATTESTATION

I have read and understand, to the best of my knowledge, the above information. I certify that all statements are truthful and accurate. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that I am financially responsible for any service considered non-covered, any deductibles and/or co-payments as well as any service denied due to non-participating provider.

________________________________ ____________________
Patient or Parent/Guardian Signature Date

____
Physician Signature

Please date and initial when reviewed:

Date: _________	Initials_________	Physician Initials_________
Date: _________	Initials_________	Physician Initials_________
Date: _________	Initials_________	Physician Initials_________
Date: _________	Initials_________	Physician Initials_________

Office Use Only

Date: _____	OC _____	OM _____
Date: _____	OC _____	OM _____
Date: _____	OC _____	OM _____
Date: _____	OC _____	OM _____
Date: _____	OC _____	OM _____