Patient Intake Form & HIPPA Release

Patient Name: _____ Date: _____

Address: _____ City: _____Zip: _____

Phone: _____E-Mail: _____

Date of Birth: _____ Social Security Number: _____

Primary Care Physician: _____ Phone Number: _____

Occupation: _____ Employer: _____

Primary Medical Insurance: _____ ID #: _____

Secondary Insurance: _____ ID #:_____

Vision Insurance: _____ ID#:_____

I authorize payment of benefits to Dr. Aleksandra Wianecka and Associates. I agree to be financially responsible for any balance not paid by my insurance plan. I understand that balances must be paid in full before next appointment.

_____ _____

Patients or responsible party signature Date

Medical History

Allergies: _____

Medications:

_____

_____

List all surgeries, injuries, hospitalizations:

_____

Have you or your family had: Crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infection or eye injury?_____

Are you pregnant or nursing? Yes No

Do you wear glasses? Yes No If Yes, how old are your current lenses? _____

Do you wear contacts? Yes No If Yes, how old are your current lenses? _____

Are you interested in refractive surgery/ LASIK? Yes No

Social History

Do you drive? Yes No If Yes, do you have any difficulty? _____

Have you ever been a tobacco user? Yes No If Yes, type, amount, how long: _____

Do you drink Alcohol? Yes No If Yes, type, amount, how long: _____

Do you use any illegal drugs/narcotics? Yes No If Yes, type, amount, how long: _____

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

_____ _____

Doctor Signature Date

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Review of Systems

Have you had any problems with the following areas?

System	Yes	No
Constitutional		
Fever Weight Loss/ Gain	Yes	No
Neurological		
Headaches	Yes	No
Migraines	Yes	No
Seizures	Yes	No
Eyes		
Loss of Vision	Yes	No
Blurred Vision	Yes	No
Distorted Vision/ Halos	Yes	No
Loss of Side Vision	Yes	No
Double Vision	Yes	No
Dryness	Yes	No
Mucous Discharge	Yes	No
Redness	Yes	No
Sandy or Gritty Feeling	Yes	No
Itching	Yes	No
Burning	Yes	No
Foreign Body Sensation	Yes	No
Excess Tearing/ Watering	Yes	No
Glare/ Light Sensitive	Yes	No
Eye Pain or Soreness	Yes	No
Chronic Infection of Eye or Lid	Yes	No
Sties or Chalazion	Yes	No
Flashes/ Floaters in Vision	Yes	No
Tired Eyes	Yes	No
Endocrine		
Thyroid/Other Glands	Yes	No
Psychiatric	Yes	No

System	Yes	No
Ears, Nose Mouth, Throat		
Allergies/ Hay Fever	Yes	No
Sinus Congestion	Yes	No
Runny Nose	Yes	No
Post-Nasal Drip	Yes	No
Chronic Cough	Yes	No
Dry Throat/Mouth	Yes	No
Respiratory		
Asthma	Yes	No
Chronic Bronchitis	Yes	No
Emphysema	Yes	No
Vascular/ Cardiovascular		
Diabetes	Yes	No
Heart Pain	Yes	No
High Blood Pressure	Yes	No
Vascular Disease	Yes	No
Gastrointestinal		
Diarrhea	Yes	No
Constipation	Yes	No
Genitourinary		
Genitals/Kidney/Bladder	Yes	No
Bones/Joints/Muscles		
Rheumatoid Arthritis	Yes	No
Muscle Pain	Yes	No
Joint Pan	Yes	No
Lymphatic/Hematologic		
Anemia	Yes	No
Bleeding Problems	Yes	No
Allergic/Immunologic		
Immunodeficiency	Yes	No
Integumentary (Skin)	Yes	No

Family History

Please note any family history (parents, grandparents, siblings, and children)

Disease/Condition	Yes	No	Relationship to You
Blindness	Yes	No	_____
Cataract	Yes	No	_____
Crossed Eyes	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Retinal Detachment/Disease	Yes	No	_____
Arthritis	Yes	No	_____
Cancer	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
High Blood Pressure	Yes	No	_____
Kidney Disease	Yes	No	_____
Thyroid Disease/Lupus	Yes	No	_____

_____ _____

Doctor Signature Date