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NEW PATIENT INFORMATION

***Please Print Legibly ***

PATIENT NAME: _____
(First) (MI) (Last)

SOC. SEC#_____/_____/_____

HOME PHONE: _____

CELL PHONE/ ALTERNATE: _____

EMAIL ADDRESS:_____

ADDRESS: _____ APT#_____

CITY:_____ STATE:_____ ZIP:_____

SEX: MALE_____ FEMALE_____ BIRTHDATE:_____ AGE:_____

MARTIAL-STATUS: MARRIED_____ SINGLE_____ DIVORCED_____

REASON FOR VISIT:_____

PRIMARY CARE PHYSICIAN: _____

ADDRESS:_____

PHONE: _____

REFERRING PHYSICIAN: _____

ADDRESS:_____

PHONE:_____

EMPLOYER:_____

ADDRESS:_____

WORK PHONE:_____

FULL-TIME_____ PART-TIME_____ RETIRED_____

PERSON TO BE REACHED IN CASE OF EMERGENCY:

_____

RELATION:_____ PHONE:_____

1) I hereby authorize Dr. Shashi Dharma's office to release written or verbal information to my doctor or insurance carrier (if the information is requested). In consideration of services rendered, I hereby assign to Dr. Dharma benefit payments due from my insurance company for medical expenses incurred which are payable to me.

2) I have been informed of or received a copy of the "Notice of Privacy Practices."

3) Payment is due at time of service! This includes all copays, deductibles, and any other non-covered items. **A *$25* fee will be charged for all "NO SHOW" appointments not canceled at least 24 hours in advanced.**

(SIGNATURE OF PATIENT) (DATE)

PATIENT HISTORY

1) Do you have now, or have you ever, had:

Medical Condition	Yes	No	Date of Onset and/or Details:
A) Diabetes Mellitus	_____	_____	_____
Treatment:	_____	_____	_____
• Diet Control	_____	_____	_____
• Oral Agents	_____	_____	_____
• Insulin	_____	_____	_____
B) Medical Complications	_____	_____	_____
• Renal Neuropathy	_____	_____	_____
• Vascular	_____	_____	_____
• Other	_____	_____	_____
C) Heart Conditions	_____	_____	_____
• Heart Attack	_____	_____	_____
• Angina or Chest Pain	_____	_____	_____
• Heart Failure	_____	_____	_____
• Irregular or Rapid Heartbeat	_____	_____	_____
• Cardiac Pacemaker Inserted	_____	_____	_____
D) High Blood Pressure	_____	_____	_____
E) Stroke or "Shock"	_____	_____	_____
F) Anemia	_____	_____	_____
G) Lung Conditions	_____	_____	_____
• Asthma	_____	_____	_____
• Emphysema and/or Bronchitis	_____	_____	_____
• Pneumonia	_____	_____	_____
• Tuberculosis	_____	_____	_____
H) Liver Disease or Jaundice	_____	_____	_____
I) Stomach or Duodenal Ulcer	_____	_____	_____
J) Kidney Stones or Other Diseases	_____	_____	_____
K) Arthritis (If YES what type?)	_____	_____	_____
L) Cancer or Tumors	_____	_____	_____

3) What other medications do you take regularly? Please give name(s) and dosage:

Medication	Dosage

4) When did you last use aspirin, in any form? _____

5) Have you had any previous eye surgery/laser, or injuries?

Eye Surgery or Laser	Date	Right Eye or Left Eye

6) What non-ocular operations have you had? Please give type(s) and date(s):

Surgery	Date

6) Are you a smoker? YES_____ NO_____

If yes, how many cigarettes per day? _____

If no, and you smoked in the past, when did you stop? _____

7) Substance abuse:

Alcohol? YES_____ NO_____

Moderate_____ Daily_____

Drug abuse? YES_____ NO_____

8) Have you gained or lost more than ten pounds in the past year? YES_____ NO_____

If yes, how many pounds have you gained? ____ or lost?_____

Please explain:

_____

_____

9) Among your blood relatives, is there a history of any of the following:

Medical Condition	**Yes**	**No**	**Relative (Mother, Father, Sibling etc)**
A) Glaucoma	_____	_____	_____
B) Cataracts	_____	_____	_____
C) "Lazy Eye" or Muscle Imbalance	_____	_____	_____
D) Retinal Disease	_____	_____	_____
E) Macular Disease	_____	_____	_____
F) Night Blindness	_____	_____	_____
G) Color Blindness	_____	_____	_____
H) Unexplained Vision Loss	_____	_____	_____
I) Diabetes Mellitus	_____	_____	_____
J) Tumor or Cancer	_____	_____	_____
K) High Blood Pressure	_____	_____	_____
L) Heart Disease	_____	_____	_____
M) Bleeding or Clotting Disorder	_____	_____	_____

10) If applicable, are you pregnant? YES_____ NO_____

M) Thyroid Disease	_____	_____	_____
N) Seizures	_____	_____	_____
O) Nervous Breakdowns	_____	_____	_____
P) Varicose Veins	_____	_____	_____
Q) DVT/Blood Clots in Legs	_____	_____	_____
R) Transfusions of Blood or Plasma	_____	_____	_____
S) AIDS, ARC, or HIV Positive Test	_____	_____	_____
T) Other Medical Problems	_____	_____	_____
U) Have you traveled to West African countries: Guinea, Nigeria, Sierra Leone, Liberia, Sengal, or Dominican Republic of the Congo in the past 21 days?	_____	_____	_____
V) Have you been in physical contact or cared for anyone with diagnosed or suspected to have Ebola Virus Disease?	_____	_____	_____
W) Have you had a fever (≥ 100.4 F) plus any one of the following symptoms: diarrhea, vomiting, headache, weakness, muscle pain, abdominal pain, or hemorrhaging?	_____	_____	_____

2) Are you allergic to any medications or to any foods? YES _____ NO_____

If yes, please describe substance(s), with date and type of reaction:

Substance	**Date**	**Reaction**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____