

COUNCIL

Optometric Center

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Olean, NY 14760
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Joseph R. Woodley, OD

Samantha Czerniak, OD

Doris Schwartz, OD

Patient Name: _____ Birth Date: _____ Age: _____ Male ___ Female ___

Primary Language: _____ Race: _____ Ethnicity: ___ Hispanic ___ Non-Hispanic

Street _____ Town _____ State _____ Zip _____ SocSec# _____

Primary Phone _____ Secondary # _____ Work # _____

Pharmacy _____ Emergency Contact _____ Phone# _____

Primary Care Physician: _____ Phone# _____

Address _____ State _____ Zip _____

We must have your insurance card so we can scan it into your chart. Medicaid, Family Health Plus, Child Health Plus, Community Card must be presented before an examination will be given.

Current Medications: please include name, strength and how often you take it. Aspirin, vitamins & herbal medications are considered medications.

Allergies to Medications or Anesthesia

SOCIAL HISTORY:

Tobacco Use: Yes No If yes, what product and how much? _____

Alcohol Use: Yes No If yes, beverage, quantity, frequency? _____

Lives: Alone With Spouse With family With friend

FAMILY HISTORY:

Arthritis Emphysema High Blood Pressure Cancer Epilepsy Stroke Diabetes Heart

Tuberculosis Glaucoma Cataracts Retinal Disease Macular Degeneration

MEDICAL HISTORY:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Difficulty Hearing | <input type="checkbox"/> Obstructive Sleep |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Any Drug Habit | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Gonorrhea/Syphilis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Back Ache/Problem | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Low Blood Sugar | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | _____ |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Joint Swelling | |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Meningitis | |

SURGICAL HISTORY: Please list the surgeries you have had.

OCULAR HISTORY:

- Cataracts Glaucoma Macular Degeneration Retinal Disease
- Retinal Detachment Diabetic Retinopathy Dry Eye Corneal Disease Corneal Abrasion
- Foreign Body - Injury _____

OCULAR SURGERY/LASER:

- Cataract: Right Eye Left Eye
- Retinal Detachment Repair: Right Eye Left Eye
- Lid Surgery: Right Eye Left Eye
- Laser: Right Eye Left Eye - For: _____
- Lasik: Right Eye Left Eye
- Glaucoma: Right Eye Left Eye
- Tear Duct Probing: Right Eye Left Eye

REVIEW OF SYSTEMS: Please circle any of the following symptoms that you are CURRENTLY having. You may also give further explanation if you wish.

- Constitution: fever, unexpected weight loss or gain, fatigue _____
- Ears/Nose/Throat: hearing loss, sinus, sore throat, nose bleeds _____
- Cardiovascular: chest pain, irregular heart beat, palpitations _____
- Respiratory: shortness of breath, wheezing, cough _____
- Gastrointestinal: heart burn, abdominal pain, diarrhea, vomiting _____
- Change in bowel habits, blood in stool _____
- Urinary: pain or discomfort, blood in urine, change in frequency _____
- Integumentary: skin rash, excessive skin dryness, itchy _____
- Musculoskeletal: muscle aches, joint pain, swollen joints _____
- Neurologic: numbness, tingling, weakness, headaches, paralysis _____
- Psychiatric: depression, anxiety _____
- Endocrine: thirst, intolerance to hot, intolerance to cold _____
- Hema/Lymph: easy bruising, easy bleeding, anemia _____