eye magination OPTICAL

David Galina O.D.

1581 Route 202 Suite 19 ~ Pomona, NY 10901 ~ 845-354-5661

Date: ____ / ____ / ____

PATIENT INFORMATION

Full Name: _____ ☐ Male ☐ Female

Address: _____ Home Phone: _____ Cell Phone: _____

City / State / Zip: _____ Work Phone: _____

Birth Date: ____ / ____ / ____ Email: _____

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed Date of last eye exam: ____ / ____ / ____

Occupation: _____ Referred by: _____

INSURANCE INFORMATION

VISION Plan Name: _____ ID#/Group#: _____

Full Name of Insured: _____ Insured's DOB: ____ / ____ / ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

MEDICAL Plan Name: _____ ID#/Group#: _____

Full Name of Insured: _____ Insured's DOB: ____ / ____ / ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

PHARMACY Name: _____ City, State & Phone: _____

MEDICAL INFORMATION

MEDICAL HISTORY:

Select any of the following medical conditions that you currently have: NONE: ☐

☐ Anxiety	☐ Colon Cancer	☐ Hearing Loss	☐ Leukemia
☐ Arthritis	☐ COPD	☐ Hepatitis	☐ Lung Cancer
☐ Asthma	☐ Coronary Artery Disease	☐ Hypertension	☐ Lymphoma
☐ Atrial Fibrillation (Irregular Heartbeat)	☐ Depression	☐ HIV / AIDS	☐ Prostate Cancer
☐ Bone Marrow Transplant	☐ Diabetes	☐ Hypercholesterolemia	☐ Radiation Treatment
☐ BPH	☐ End Stage Renal Disease	☐ Hyperthyroidism	☐ Seizures
☐ Breast Cancer	☐ GERD	☐ Hypothyroidism	☐ Stroke

☐ Other: _____

PAST SURGERIES:

Have you had any surgeries on the following organs: NONE: ☐

☐ Appendix	☐ Ovaries _____
☐ Bladder	☐ Pancreas _____
☐ Breast _____	☐ Prostate _____
☐ Colon _____	☐ Rectum _____
☐ Gallbladder	☐ Skin _____
☐ Heart _____	☐ Spleen
☐ Joint Replacement ☐ Hip ☐ Knee	☐ Testicles
☐ Kidney _____	☐ Uterus _____
☐ Liver	
☐ Other: _____	

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Medical Information Continued

Ocular History:

Select any of the following that apply and circle Right or Left eye: NONE: ☐

- ☐ Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Cataract: Right / Left
- ☐ Contact Lenses
- ☐ Corneal Dystrophy: Right / Left
- ☐ Diabetic Retinopathy Background: Right / Left
- ☐ Diabetic Retinopathy Proliferative: Right / Left
- ☐ Dry Eyes
- ☐ Glasses
- ☐ Glaucoma: Right / Left
- ☐ Macular Degeneration: Right / Left
- ☐ Macular ERM: Right / Left
- ☐ Narrow Angles: Right / Left
- ☐ Ocular Hypertension: Right / Left
- ☐ Ophthalmic Migraine: Right / Left
- ☐ Pseudoexfoliation
- ☐ Retinal Tear: Right / Left
- ☐ Stabismus
- ☐ PVD OD: Right / Left
- ☐ Vitreous Floaters: Right / Left
- ☐ Other: _____

Ocular Surgery:

Select any of the following that apply and circle Right or Left eye: NONE: ☐

- ☐ Blepharoplasty: Right / Left
- ☐ Cataract Surgery: Right / Left
- ☐ Corneal Transplant: Right / Left
- ☐ DSAEL: Right / Left
- ☐ Eye Muscle Surgers
- ☐ Intravitreal Injections: Right / Left
- ☐ LASIK: Right / Left
- ☐ LPI: Right / Left
- ☐ LPT: Right / Left
- ☐ PRK: Right / Left
- ☐ Ptosis Repair: Right / Left
- ☐ Punctual Plugs: Right / Left
- ☐ Strabismus Surgery: Right / Left
- ☐ Retinal Laser: Right / Left
- ☐ Trabeculectomy: Right / Left
- ☐ Tube Shunt: Right / Left
- ☐ Yag Capsulotomy: Right / Left
- ☐ Other: _____

Medications and Allergies

Name of family doctor (PCP): _____

Current medication(s)-List: Check if none: ☐

1) _____
2) _____
3) _____
4) _____
5) _____

Allergies to medication? ☐ Yes ☐ No Which? _____ Reactions? _____

What is your general health? _____

Family History

High Blood pressure	☐ Yes	☐ No	Relation	_____	Retinal detachment	☐ Yes	☐ No	Relation	_____
Diabetes	☐ Yes	☐ No	Relation	_____	Cataracts	☐ Yes	☐ No	Relation	_____
Glaucoma	☐ Yes	☐ No	Relation	_____	Melanoma	☐ Yes	☐ No	Relation	_____
Macular degeneration	☐ Yes	☐ No	Relation	_____	Other:	_____			