Deadwood Eyecare

David Czerny OD - Jessica Czerny OD, DVM - Jordyn Stevens OD - Jonathan Nebelsick, OD

88 Charles St--Deadwood SD 57732 -- (605)-578-1761 **DATE**_____

Patient Name_____ Date of Birth_____ Social Security No._____

Address_____ City _____State_____ Zip_____

Home Phone_____ Work Phone_____Cell Phone_____

Occupation_____Employer_____

Spouse or parent_____ Spouses place of employment_____

Name of last eye Dr. and date of last exam_____

Referred BY? _____ **Patient Email Address**_____

MEDICAL INFORMATION

Do you or have you ever had any of the following?

Y N Ears/nose/mouth/throat problems _____
Y N Constitutional (Fever/Unexplained weight loss/gain)_____
Y N Cardiovascular (Heart Disease etc)_____
Y N Respiratory Disease (ex COPD)_____
Y N Tuberculosis _____
Y N Gastrointestinal disease (ex Crohn's)_____
Y N Genitourinary disease (ex Kidney Disease)_____
Y N Arthritis (specify type) _____
Y N Muscle Pain _____
Y N Skin Conditions_____
Y N Headaches _____
Y N Other Neurologic problems (MS etc.)_____
Y N Psychiatric _____
Y N Endocrine disease (Thyroid etc.) _____
Y N Diabetes Type_____
Y N Hematologic/lymphatic (ex Blood Disease)_____
Y N Hepatitis A/B/C _____
Y N Have you ever tested positive to HIV or other Infectious Disease (please specify)_____
Y N Allergic/Immunologic _____
Y N Cancer (specify type below) _____

Y N Watery/red/itchy eyes
Y N Dry Eyes
Y N Floaters/spots
Y N Flashes of light
Y N Double Vision
Y N Amblyopia (Lazy eye)
Y N Strabismus (Eye turn)

PERSONAL INFORMATION Are you pregnant or nursing? Y N

Weight _____LB Ethnicity: Hisp/Lat Not-Hisp/Lat Decline

Height ____FT____IN Race: Afr-Am Cauc Asian Hisp Am- Ind Decline

Any other medical problems not listed above:

_____

_____

Do you have any medication allergies… If YES what type of reaction
Yes/No_____

_____

Are you taking any medications Y N Please list:

_____

_____

Have you had any operations_____

_____

Name of family doctor_____Date of last visit_____

Social History

Are you a: Current smoker___ b: Never smoker___ C: Previous smoker___(IF you have habitually smoked, How many years?_____

Do you drink alcohol Yes/No How much_____

Do you use any other drugs Yes/No_____

FAMILY HISTORY (list any family members who may have the following)

Macular Degeneration Yes/No Relation_____

Diabetes Yes/No Relation_____

Glaucoma Yes/No Relation_____ Heart Disease Yes/No Relation_____

Autoimmune Disease Yes/No Relation_____ Thyroid Disease Yes/No Relation _____

Other genetic disease Yes/No _____

PERSONAL EYE INFORMATION

Eye conditions or problems Yes/No_____

Eye Operations Yes/No_____Date_____

Eye Injuries Yes/No_____Date_____

Glaucoma	Yes/No	Cataracts	Yes/No
Macular Degeneration	Yes/No	Retinal Detachments	Yes/No

Signature on file:

I authorize release of relevant medical information to the following person(s):

Name_____Relationship_____

Name_____Relationship_____

I acknowledge that a copy of the Notice of Privacy Practices for Deadwood Eyecare was made available to me and I authorize the release of information to my insurance companies. **I understand that I am responsible for any amount not covered by my insurance**

Sign_____Date_____