

PATIENT INFORMATION FORM
ROBERT G. FANTE, MD

Patient Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Telephone: Home _____ Work _____ Cell/Pager _____

Email address: _____ Employer _____ Occupation _____

Date of Birth _____ SS# _____ Gender F M

Marital Status Single Married Divorced Widowed Other _____

Spouse's Name _____ Work Phone _____

Parents' Names (if child) _____ Work Phone _____

INSURANCE INFORMATION

Primary Insurance _____

Subscriber Name _____ Date of Birth _____

Secondary Insurance _____

Subscriber Name _____ Date of Birth _____

Are you currently employed? Y N Is your spouse or other family member employed? Y N

Have you ever served in the military? Y N Are you here for an injury from work? Y N

Do you have secondary insurance? Y N Are you covered under any other healthcare plan? Y N

Are your injuries accident related? Y N Are you covered under an employer? Y N

REFERRAL INFORMATION

Who sent you to our office? _____

Reason for appt _____

PHYSICIAN INFORMATION

General Doctor _____ Telephone _____

Ophthalmologist _____ M.D. Telephone _____

Optometrist _____ O.D. Telephone _____

Other Specialist Doctors (cardiology, endocrine, cancer, plastic surgery, etc):

Name _____ Specialty _____ Telephone _____

Name _____ Specialty _____ Telephone _____

EMERGENCY INFORMATION

Person to Notify _____

Relationship to you _____ Telephone _____

Confidential Medical History Form

Robert G. Fante, M.D., P.C.

PATIENT NAME: _____ DATE: _____

1. Please list all medications you take on a regular basis:

(Please include any eye drops, vitamins, herbs, or over the counter products such as aspirin or aspirin containing products.)

| <u>Medication</u> | <u>Strength</u> | <u>Frequency</u> |
|-------------------|-----------------|------------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |

2. Please list all illnesses/diseases which you have had or have now:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

3. Please list all prior surgeries or procedures:

| <u>Surgery</u> | <u>Physician</u> | <u>Approximate Date</u> |
|----------------|------------------|-------------------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

4. Please list any allergy or sensitivity to medication or food:

| <u>Medication</u> | <u>Reaction</u> |
|-------------------|-----------------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

Patient Name: _____

5. Has anyone in your family had the same problem that brings you to our office?

Yes No If yes, who? _____

Do any of these diseases run in your family. If YES, please note relationship __Glaucoma

Do you smoke? If YES, how much? _____

__Diabetes _____
__High blood pressure _____
__Skin cancer _____
__Other _____

Drink alcohol? If YES, how much? _____

6. Do any of the following problems apply to you? If YES, please explain.

| | | |
|---|--|--|
| Constitutional (fever, weight loss, poor appetite, etc.) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Eyes (glaucoma, cataract, lazy eye, retina problems, etc) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Ear/Nose/Throat (hearing loss, sinus problems, sore throat, frequent bloody noses, etc) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Cardiovasc (heart problems, chest pain, high blood pressure, stroke, pacemaker, heart surgery) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Respiratory (asthma, shortness of breath, wheezing, coughing, etc) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Gastro-intestinal (heartburn, diarrhea, vomiting, abdominal pain, etc) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Genito-urinary (urinary problems, blood in urine, etc) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Skin (skin rashes, excessive dryness, used accutane, skin cancer/diseases, etc) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Musculoskeletal (muscle aches, joint pain, swollen joints, artificial joint, arthritis, etc) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Neurological (numbness, weakness, paralysis, headaches, spasm, MS, etc) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Hematologic (blood disorders, leukemia, easy bleeding/bruising, take aspirin, etc) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Allergy (hay fever, seasonal allergies, etc) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Endocrine (thyroid or pituitary problems, etc) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Psychiatric (depression, anxiety, etc) | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Hepatitis B or C, HIV or AIDS, Tuberculosis, etc | <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Diabetes, radiation treatments, anesthesia problems, etc. | <input type="checkbox"/> yes <input type="checkbox"/> no | |

Other Comments: _____

Physician Initials _____ Date _____