Retina Associates of St. Louis

NEW PATIENT INFORMATION

Patient Name: _____
(last) (first) (middle initial)

Birth Date: _____ Social Security Number: _____

Gender: ❑ Male ❑ Female Status: ❑ Single ❑ Married ❑ Widow ❑ Divorced

Spouse Name: _____ Spouse Birth Date: _____

Spouse Social Security Number: _____

Patient's Employer: _____ Employer Phone: _____

Employer's Address: _____

EMERGENCY INFORMATION

Nearest Relative/Friend not living with you: _____

Relationship to Patient: _____ Phone Number: _____

Referring Doctor: _____ Phone Number: _____

May we contact you by mail? ❑ Yes ❑ No

May we leave a message on your answering machine? ❑ Yes ❑ No

If YES please provide phone number _____

May we leave a message with another person if you are unavailable? ❑ Yes ❑ No

May we fax information to you? ❑ Yes ❑ No

If YES please provide fax number _____

May we send information to you via e-mail? ❑ Yes ❑ No

If YES please provide email address _____

Any additional methods? _____

MEDICAL HISTORY

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with your eyes. Thank you for answering the following questions.

Are you under a physician's care now? ❑ Yes ❑ No

If YES, please list your medical problems and date problem started.

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

Have you ever been hospitalized or had major operations? ❑ Yes ❑ No

If YES, please list procedures and dates.

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

Please bring a list of all your medications to your office visit.