PATIENT NAME: _____SS# _____
LAST FIRST MIDDLE

ADDRESS: _____COUNTY_____
STREET CITY STATE ZIP

HOME PHONE #:_____CELL #:_____EMAIL:_____

Would you like to receive text and/or email appointment reminders? Yes ☐ No ☐

BIRTHDATE:_____ AGE:_____ SEX:_____

RACE (OPTIONAL): _____ETHNICITY (OPTIONAL): _____

EMPLOYMENT STATUS: ____FULL-TIME ____PART-TIME ____RETIRED ____NONE

PATIENT'S EMPLOYER: _____OCCUPATION:_____

EMPLOYER ADDRESS: _____
STREET CITY STATE ZIP

EMPLOYER PHONE #:_____

MARITAL STATUS: ____ SINGLE ____ MARRIED ____WIDOWED ____DIVORCED

RESPONSIBLE PARTY:_____SS#_____BIRTHDATE:_____

ADDRESS (if different than patient's):_____
STREET CITY STATE ZIP

PHONE # (if different than patient's):_____

RESPONSIBLE PARTY'S EMPLOYER:_____EMPLOYER PHONE #: _____

EMERGENCY CONTACT:_____EMERGENCY PHONE #:_____

REFERRED BY: DOCTOR_____FRIEND/RELATIVE:_____

OTHER:_____

CONSENT FOR TREATMENT/AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I hereby consent to examination and treatment by Daniel Ewen, M.D., including diagnostic and/or therapeutic procedures ordered by the physician, and obtaining medication history.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND RELEASE INFORMATION

I hereby authorize release of any medical information necessary to process claims and request that payments be made directly to the facility, Bluegrass Eye and Laser. I understand that I am financially responsible for all charges whether or not paid by said insurance. A copy of this authorization will remain on file for all future treatment. I authorize said assignee to release all information to secure payment.

SIGNATURE:_____ DATE:_____

DANIEL A. EWEN, M.D., F.A.C.S., Ophthalmology
Medical Doctor, Diseases of the Eye, and Eye Surgery

BLUEGRASS EYE AND LASER
DANIEL A. EWEN, M.D., F.A.C.S., Ophthalmology
Medical Doctor, Diseases of the Eye, and Eye Surgery
2580 Bypass Road, PO BOX 4277
Winchester, KY 40392
PH: 859-745-3060 Toll Free: 1-888-463-5377

DATE:_____
PATIENT NAME:_____ FAMILY DOCTOR:_____
DATE OF LAST EXAM:_____ DATE OF LAST EYE EXAM:_____
EDUCATION-CIRCLE HIGHEST LEVEL COMPLETED:
GRADE: 1 2 3 4 5 6 7 8 9 10 11 12 COLLEGE POST GRADUATE
OCCUPATION:_____ RETIRED: ____YES ____NO
NUMBER OF CHILDREN:_____ NUMBER OF BROTHERS AND SISTERS:_____
ARE YOU LEFT OR RIGHT HANDED?_____
HAVE YOU HAD A TETANUS SHOT WITHIN THE LAST 5 YEARS?_____
ARE ALL IMMUNIZATIONS UP TO DATE?_____

HAVE YOU EVER TESTED POSITIVE FOR ANY ONE OF THE FOLLOWING:
HEPATITIS: ____NO ____YES TUBERCULOSIS (TB): ____NO ____YES
AIDS (HIV): ____NO ____YES HISTOPLASMOSIS: ____NO ____YES
SEXUALLY TRANSMITTED DISEASE ____NO ____YES

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? ____NO ____YES
HAVE YOU EVER HAD A BLOOD TRANSFUSION? ____NO ____YES
CURRENT WEIGHT:_____ ONE YEAR AGO:_____ MAXIMUM WEIGHT:_____ WHEN:_____
IF KNOWN, PLEASE PROVIDE LAST CHOLESTEROL MEASUREMENT:_____

HAVE YOU EVER WORN CONTACTS: ____NO ____YES
IF YES, PLEASE ANSWER THE FOLLOWING:
HOW MANY YEARS OF WEAR:_____ LAST WORN:_____
HOW OLD IS CURRENT PAIR:_____ TYPE OF CONTACTS: ____HARD ____SOFT
____DISPOSABLE ____TORIC ____EXTENDED WEAR ____GAS PERMEABLE

REASON FOR TODAY'S VISIT:_____
DRUG ALLERGIES OR REACTIONS:_____

PHARMACY:_____
PLEASE LIST CURRENT MEDICATIONS:
MEDICATION_____DOSE_____FREQUENCY_____
MEDICATION_____DOSE_____FREQUENCY_____
MEDICATION_____DOSE_____FREQUENCY_____
MEDICATION_____DOSE_____FREQUENCY_____
IF MORE, PLEASE USE BACK OF THIS FORM OR PROVIDE A COMPLETE LIST OF MEDICATIONS TO OFFICE STAFF

FAMILY HISTORY: PLEASE CHECK MARK IF ANY BLOOD RELATIVE EVER HAD ANY OF THE FOLLOWING:

	RELATIONSHIP TO YOU:		RELATIONSHIP TO YOU:
___	CANCER_____	___	GLAUCOMA _____
___	TUBERCULOSIS (TB)_____	___	BLINDNESS _____
___	DIABETES_____	___	CATARACT _____
___	HEART TROUBLE_____	___	MACULAR DEGENERATION_____
___	HIGH BLOOD PRESSURE_____	___	RETINAL DETACHMENT_____
___	STROKE_____	___	LAZY EYE_____
___	EPILEPSY_____	___	CROSSING EYES_____
___	MIGRAINE_____	___	RETINITIS PIGMENTOSA_____

SOCIAL HISTORY:

ARE YOU A CURRENT OR FORMER SMOKER?_____

NUMBER OF YEARS SMOKED:_____ PACKS PER DAY:_____

ALCOHOL USE: ____NO ____YES AMOUNT:_____

HAVE YOU EVER BEEN HOSPITALIZED FOR ANY ILLNESS? ___NO ____YES IF SO, WHEN:_____

HAVE YOU EVER BEEN ADVISED TO HAVE ANY SURGICAL OPERATION WHICH HAS NOT BEEN DONE?_____

IF SO, PLEASE EXPLAIN:_____

SURGICAL HISTORY: PLEASE CHECK MARK ANY SURGERIES THAT YOU HAVE HAD:

___APPENDIX SURGERY	___HERNIA SURGERY	___HIP SURGERY
___BACK SURGERY	___HEART SURGERY	___TONSILLECTOMY
___KNEE SURGERY	___CESAREAN SECTION	___NECK SURGERY
___BREAST/MASTECTOMY SURGERY	___HYSTERECTOMY	___CARPAL TUNNEL SURGERY
___GALL BLADDER SURGERY	___DILATION AND CURETTAGE (D&C)	OTHER:_____

PATIENT PAST MEDICAL HISTORY: PLEASE CIRCLE YES OR NO

		ADDITIONAL INFORMATION			ADDITIONAL INFORMATION
NO/YES	CROSSED/LAZY EYE	_____	NO/YES	HEAD INJURY/ CONCUSSION	_____
NO/YES	ANXIETY DISORDER	_____	NO/YES	HEADACHES	_____
NO/YES	ARTHRITIS	_____	NO/YES	HEART DISEASE	_____
NO/YES	BLOOD DISORDERS	_____	NO/YES	HIGH CHOLESTEROL	_____
NO/YES	CANCER	_____	NO/YES	HIGH BLOOD PRESSURE	_____
NO/YES	CORONARY ARTERY DISEASE	_____	NO/YES	KIDNEY DISEASE	_____
NO/YES	DEPRESSION	_____	NO/YES	LIVER DISEASE	_____
NO/YES	DIABETES	_____	NO/YES	LUNG DISEASE	_____
	IF DIABETIC, DO YOU TAKE INSULIN:	_____	NO/YES	MENINGITIS	_____
	LAST GLUCOSE/SUGAR READING:	_____	NO/YES	MULTIPLE SCLEROSIS	_____
	MOST RECENT A1C READING:	_____	NO/YES	NEUROLOGIC DISORDER	_____
NO/YES	DOUBLE VISION	_____	NO/YES	PSYCHIATRIC/MENTAL PROBLEM	_____
NO/YES	EYE TRAUMA	_____	NO/YES	SEASONAL ALLERGIES	_____
NO/YES	FLOMAX USE PAST OR PRESENT (PRESCRIPTION MEDICATION USED FOR PROSTATE, ETC.)	_____			
NO/YES	GASTROINTESTINAL DISEASE	_____	NO/YES	SLEEP APNEA	_____
NO/YES	THYROID DISEASE	_____	NO/YES	STROKE	_____