Annan Retina Eye Center
Update Patient Information Form

Please review the following and complete if changed since your last visit. Please provide your insurance card(s) for us to copy as well. Thank you!

Name:_____ Date: _____
(Last) (First) (Middle) (Nickname)

NEW Address: _____
NEW City, State, Zip Code: _____
Home Phone:_____ Mobile/Cell Phone: _____
Work Phone:_____ Other: _____
Email address:_____ ***By providing my email, I understand that medical information may be sent to this email address.***

Emergency Contact:_____ Relationship:_____
Emergency Contact Telephone #'s _____
Eye Doctor:_____ Primary Doctor(s):_____
Reason for Visit today: _____
List any eye problems or eye surgery since last visit:_____

Employed/Retired/Student/Unemployed Employer:_____
Marital Status (circle one): Married/Divorced/Separated/Widowed/Single/Partner/Child
Since last visit have you been diagnosed with any of the following? Please provide details if "Yes" circled.

Yes No Diabetes_____

Yes No High Blood Pressure_____

Yes No Heart Disease_____

Yes No Respiratory Disease_____

Yes No Gastrointestinal Disease_____

Yes No Liver Disease or Hepatitis_____

Yes No Prostate Disease_____

Yes No Cancer_____

Yes No Kidney Disease_____

Yes No HIV, Infectious Disease_____

List NEW medications, including dose:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

List NEW eye drops that you are currently using:

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

Please list any drug allergies or note below if you are allergic to Latex or adhesives.

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

Please circle any of the listed symptoms that you are <u>currently</u> experiencing:

feeling poorly	lack of energy	fever/ chills
trouble seeing	trouble hearing	chest pain
shortness of breath	nausea	vomiting
diarrhea	weakness	rash
depression	difficulty with speech, memory, or cognition	

Has anyone in your family ever been diagnosed with any of the following (since your last visit)? (Please circle if yes):

Diabetes	Macular Degeneration	Retinal Disease
Glaucoma	Cataracts	Cancer
Heart Disease	Stroke	

Do you drink alcohol?_____If yes, how much?_____
Do you smoke?_____If yes, how much?_____

Please provide our business office staff with your insurance card (s). A new HIPAA signature sheet is required to be signed as well every six months. We appreciate your patience. We are grateful to be entrusted in your care.