



**GOODMAN
EYE • CENTER**

Patient Demographic/Intake Form

Salutation: Dr./Mr./Mrs./Ms./Miss

Last Name First Name Middle Name

Gender: Male Female Other: _____

Date of Birth

Street Address City State Zip Code

Cell Phone Home Phone Email Address

Preferred mode of contact: Race: Ethnicity:

- Cell phone – call
- Cell phone – text
- Home Phone
- Email

- American Indian/Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____
- Decline to answer

- Hispanic or Latino
- Not Hispanic or Latino
- Decline to answer

Occupation Employer Work Phone

Emergency Contact Person Emergency Contact Phone Relation to Emergency Contact

Legal Guardian (if under 18) Legal Guardian's Contact Phone Relation to Legal Guardian

Whom May We Thank for this Referral?

- Doctor: _____ Google/Facebook/Yelp
- Friend: _____ Other: _____

Reason for Appointment: _____

Other Medical History: No history of illnesses

- | | | |
|--|--|---|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Headache | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polymyalgia Rheumatica |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rosacea/Dermatitis |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sarcoidosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Keloid Formation | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> STD |
| <input type="checkbox"/> Diabetes (Type 1 or Type 2) | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Currently pregnant or breastfeeding | | |

Other _____

General Surgeries/Procedures: (Please list and date)

_____	_____	_____
_____	_____	_____
_____	_____	_____

All Other Medications: (Please list)

Name	How much and how often?	What for?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: (Please indicate relationship) No history of illnesses

- | | | | |
|------------------------------------|--|---|--|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> History unknown |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Retinal Disease | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Other _____ | |

Social History: (Please mark all that apply)

Smoking: current every day smoker current some day smoker
 former smoker never smoked

Alcohol Use: No Yes If yes, how much and how often? _____

Drug Use: No Yes If yes, which and how long? _____