

Benavente EyeCare

Jorge A. Benavente, O.D.

9175 Calumet Ave. Munster, IN 46321 (219)-836-7800

Demographic Information

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Home: (____) _____ Mobile: (____) _____ Work (____) _____

Email: _____ Date of Birth: _____ SSN: _____

Occupation: _____ Employer: _____ Medical Insurance: _____

Vision Insurance: _____ How did you hear of us: current patient / internet / insurance / referral: _____

Emergency Contact Name/Phone Number: _____ **Relationship:** _____

Ocular History Last Eye Exam: _____ Eyeglasses: Y / N Contact Lens Wear: Y / N

If yes: contact lens brand or type: _____ contact lens solution: _____

Have you ever been diagnosed with or treated for any of the following eye conditions:

	Self		Self	Family (indicate if siblings, parents or grandparents)
Eye Infection	Y / N	Glaucoma	Y / N	Y / N
Eye Injury	Y / N	Macular Degeneration	Y / N	Y / N
Eye Surgery	Y / N	Cataract	Y / N	Y / N
Flashes of Light / Floaters	Y / N	Retinal Detachment	Y / N	Y / N
Dry / Red / Gritty	Y / N	Amblyopia/Lazy Eye	Y / N	Y / N

Other eye condition(s) or symptom(s) not listed above: _____

If yes to any questions above regarding YOURSELF, please explain diagnosis / treatment: _____

Medical History

Name of Primary Medical Doctor: _____ Last Medical Exam: _____

Please list **MEDICATIONS** you take, both Prescribed and Over-the-Counter: _____

Please list any **Medication Allergies**: _____

Do **YOU** currently have a diagnosis **or** have ever been diagnosed with any of the following health conditions:

Diabetes (type I or II)	Y / N	Fever > 10 days or unexplained weight loss or gain	Y / N
Thyroid (hyper or hypo)	Y / N	Autoimmune disease (lupus, rheumatoid arthritis, etc)	Y / N
High Cholesterol	Y / N	Gastrointestinal (colitis, crohn's disease, etc)	Y / N
High Blood Pressure	Y / N	Genitourinary (kidney disease, bladder, etc)	Y / N
Heart Disease	Y / N	Skin (Acne, Eczema, etc)	Y / N
Stroke	Y / N	Ear / nose / throat conditions	Y / N
Seizures	Y / N	Allergy (environmental or food)	Y / N
Migraine / Headache	Y / N	Respiratory: asthma / bronchitis / emphysema / COPD	Y / N
Arthritis/Joint or Muscle pain	Y / N	Depression, anxiety, or other psych. disorder:	Y / N
Other:	Y / N	Surgery:	Y / N

Please Explain diagnosis date & treatment for conditions noted above: _____

Family Medical History:

Social History:

If Yes, type / amount / frequency?

High blood pressure or heart disease	Y / N	Do you smoke or use tobacco products?	Y / N
Diabetes	Y / N	Do you drink alcohol?	Y / N
Stroke	Y / N	Do you use other substances?	Y / N

My signature below acknowledges that I have answered the above questions regarding my health history to the best of my ability. I also acknowledge HIPPA privacy practices notice is available for review at my request.

Signature of Patient or Legal Guardian

Name Legal Guardian (printed) if applicable

Date

Doctor Initials/Date