Dr. Kenneth Guthrie

Date: _____

Please turn in your Driver's License and all insurance cards with your paperwork

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: (home or cell?) _____ Date of Birth: _____

Social Security Number: _____ Age: ____ Sex: M F Status: M S W D

Employer: _____ Work Phone: _____

Email: _____ Primary Care Physician: _____
Responsible Party: _____ Relationship to Patient: _____

Do you have MEDICAL insurance? Y N Name of insurance:_____
Primary Policy Holder:_____
Do you have VISION insurance? Y N Name of insurance:_____
Primary Policy Holder:_____

Medications: (please list ALL current medications, if no medications please write NONE)
_____
_____

Drug Allergies: _____

List major injuries, surgeries, and/or hospitalization you have had:
_____
_____

List EYE history: surgeries, eye injuries, crossed eyes, lazy eye, drooping lid, glaucoma, retinal disease, cataracts, cataract surgery, infections, or any other eye related condition:
_____

Are you Diabetic? **Y N How long?** _____
____Insulin
____Non-Insulin
Do you have lupus? Y N How long? _____

Have you been infected with any of the following?
___ Gonorrhea ___ HIV ___ Hepatitis ___ Syphilis ___ None

Family Medical History: Please note relationship to yourself **(mother, paternal grandfather, etc.)**

Blindness	_____
Cataracts	_____
Macular Degeneration	_____
Glaucoma	_____
Retinal Detachment/Disease	_____
Lupus	_____
Diabetes	_____
Heart Disease	_____
Kidney Disease	_____
Thyroid Disease	_____
Other _____	_____

Reason for visit today: **(Example: Blurry distance vision, Needs new contacts, etc.)**

_____

_____

Do you use illegal drugs? Y N Do you use alcohol Y N

Do you use tobacco? Y N Are you pregnant? Y N
If yes, Type/AMT/How Long? _____ Approximate due date? ____

Have you ever used tobacco? Y N

Last Eye Exam: _____ Last Eye Doctor: _____

Do you wear glasses? Y N Do you wear Contacts? Y N __soft __gas perm

Review of Systems: Please check all that apply to you.

Eyes
_Vision Loss
_Blurry Vision
_Distorted Vision
_Double Vision
_Dryness
_Redness
_Mucous Discharge
_Gritty Feeling
_Itching
_Burning
_Excess Watering
_Light Sensitivity
_Eye Pain/Soreness
_Chronic Infection
_Sties
_Flashes
_Floating Spots
_Tired Eyes
_Cataracts
_Diab. Retinopathy
_Glaucoma
_Macular Degen.
_Retinal Detach.

Gastrointestinal
_Colitis
_Crohn's Disease
_Ulcers
_Constipation
_Diarrhea

Constitutional
_Fever
_Weight Loss/Gain
_Fatigue
_Trauma

Integumentary(skin)
_Eczema
_Rosacea
_Psoriasis

Neurologic
_Headaches
_Migraines
_Seizures
_Mult. Sclerosis
_Stroke

Endocrine
_Non-Insulin Diabetes
_Insulin Diabetes
_Thyroid Dysfunction

Respiratory
_Asthma
_Bronchitis
_Emphysema

Cardiovascular
_Heart Disease
_Hypercholesterolemia
_Hypertension

Ears/Nose/Throat
_Allergies
_Sinus Congestion
_Runny Nose
_Post Nasal Drip
_Chronic Cough
_Dry Throat/Mouth

Allergic/Immune
_Drug Allergies
_Seasonal Allergies
_Lupus
_Arthritis

Lymphatic/Hematologic
_Anemia
_Bleeding Problems
_Leukemia

Musculoskeletal
_Fibromyalgia
_Muscular Dystrophy
_Osteoarthritis
_Ankylosing Spond.

Genitourinary
_Kidney Problems
_Bladder Problems
_STD's

Patient Signature: _____ Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I, patient, have received a copy of this office's Notice of Privacy Practices.

_____

Print Name

_____

Signature

_____

Date

Release of Medical Information
(HIPPA Release Form)

[ ] I authorize the release of information, including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Name: _____

DOB:_____

Relationship:_____

Name: _____

DOB:_____

Relationship:_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signature: _____ Date:_____