Emily C. Flores, O.D.
Romero R. Flores, O.D.
601-B Graham Street, SW
Cullman, AL 35055

Patient Information/History

Name: _____ Date: _____
Address:_____ Phone: _____
City: _____ State: _____ Zip:_____ Work/Cell: _____
DOB:____/____/_____ Age: _____ Gender: □ male □ female SS#: _____/_____/_____
Marital Status: Single_____ Married_____ Divorced_____ Widowed_____
Employer/School: _____ Occupation/Grade: _____
Person In Charge of Account: _____Relationship: _____
Email: _____
How did you hear about our office? □ Insurance Company □ Yellow Pages □ Shopper's Guide Ad
□ Billboard □ Personal Referral: Name_____
□ Other: _____

INSURANCE INFORMATION
Vision Insurance
Insurance Company: _____
Policy Holder's Name_____ DOB: _____/_____/_____
Contract # or SS# of Policy Holder_____
Medical Insurance
Insurance Company: _____
Policy Holder's Name_____ DOB:_____/_____/_____
Contract #_____ Group#_____

MEDICAL HISTORY
Primary Care Physician: _____
Phone: _____ Date of last physical exam: _____
Current Medications (including over the counter meds): _____
_____
Allergies to medications: _____
Major surgeries or hospitalizations: _____
Are you Pregnant? _____ Nursing? _____ Due date if pregnant? _____
Date of Last Eye Exam: _____ Doctor seen: _____
Do you wear glasses? _____ if so, how old is current pair? _____ Circle: Bifocals/Trifocals/Progressive
Do you wear contacts? _____ Brand? _____ Do you sleep in them? _____

OTHER
Hobbies: _____ Computer use: _____ Hours per day: ____
Do you use tobacco? _____ If yes: What type/amount/how long? _____
Do you drink alcohol? _____ If yes: What type/amount/how long? _____
Do you use illegal drugs? _____ If yes: What type/amount/how long? _____

MEDICAL/OCULAR HISTORY

Do you or any of your family members have a history of the listed conditions, living or deceased?

Blindness	□ yes	□ no	Relationship: _____
Cataracts	□ yes	□ no	Relationship: _____
Glaucoma	□ yes	□ no	Relationship: _____
MacularDegeneration	□ yes	□ no	Relationship: _____
Retinal Detachment	□ yes	□ no	Relationship: _____
Lazy/Crossed eye	□ yes	□ no	Relationship: _____
Diabetes	□ yes	□ no	Relationship: _____
High Blood Pressure	□ yes	□ no	Relationship: _____
Lupus	□ yes	□ no	Relationship: _____
Thyroid	□ yes	□ no	Relationship: _____

Other: _____

Circle any of the following ocular problems you experience:

Loss of Vision	Blurred Vision	Distorted Vision	Loss of Side Vision
Dryness	Redness	Mucous Discharge	Glare/Light Sensitivity
Itching	Burning	Eye Pain	Foreign Body Sensation
Excessive Watering	Styes	Flashes/Floaters	Double Vision

REVIEW OF SYSTEMS—Are you currently experiencing any of the following problems?

ALLERGIC	□ yes	□ no	LYMPHATIC/HEMATOLOGIC		
			Anemia	□ yes	□ no
VASCULAR/CARDIOVASCULAR			Bleeding problems	□ yes	□ no
Stroke	□ yes	□ no			
High blood pressure	□ yes	□ no	IMMUNOLOGIC		
Vascular disease	□ yes	□ no	HIV	□ yes	□ no
			Other immune problems	□ yes	□ no
CONSTITUTIONAL					
Fever, Weight loss/gain	□ yes	□ no	INTEGUMENTARY (skin)		
Weakness/Dizziness	□ yes	□ no	Eczema	□ yes	□ no
ENDOCRINE			BONES/JOINTS/MUSCLES		
Thyroid/other glands	□ yes	□ no	Arthritis	□ yes	□ no
Diabetes	□ yes	□ no	Scoliosis	□ yes	□ no
			Myesthenia Gravis	□ yes	□ no
GASTROINTESTINAL					
Acid Reflux	□ yes	□ no	NEUROLOGICAL		
Other GI Disorder	□ yes	□ no	Headaches	□ yes	□ no
			Migraines	□ yes	□ no
GENITOURINARY			Seizures	□ yes	□ no
Genitals/kidneys/bladder	□ yes	□ no			
Sexually transmitted diseases	□ yes	□ no	PSYCHIATRIC	□ yes	□ no
EARS, NOSE, MOUTH THROAT			RESPIRATORY		
Sinusitis	□ yes	□ no	Asthma	□ yes	□ no
Dental Disease	□ yes	□ no	Chronic bronchitis	□ yes	□ no
Ear Infections	□ yes	□ no	COPD	□ yes	□ no

If you answered yes to any of the above or have other unlisted conditions, please explain:

_____

_____