Date:_____

Name:_____ Race/Ethnicity:_____

Marital Status: Single Married Divorced Widowed

Place of Employment:_____ Position_____

Primary Care Doctor:_____ City:_____

Phone:_____ Fax:_____

Have you been diagnosed with any eye problems in the past? _____

_____

_____

Are you having any problems with your eyes?_____

Do you or any of your family any history of the following eye diseases:

Macular Degeneration Yes_____ No_____Relation:_____

Glaucoma Yes_____ No_____Relation:_____

Other:_____

Please list any medical conditions and any surgical history:_____

_____

Do you have any known drug allergies?_____

Are you allergic to fluorescein? Yes_____ No:_____

Please list any medications you are currently taking:_____

_____

Do you have problems with any of the following: If yes, please explain where applicable

Fever	Yes_____No____	Weight Loss	Yes_____No____
Heart	Yes_____No____	Ear/Nose/Throat	Yes_____No____
Endocrine	Yes_____No____	Respiratory	Yes_____No____
GI	Yes_____No____	Muscular	Yes_____No____
Skeletal	Yes_____No____	Skin	Yes_____No____
HIV	Yes_____ No____	TB	Yes_____No____

Do you smoke? Yes_____ No_____ If so, packs per day:_____Years Smoking:_____

Do you drink? Yes_____ No_____ Socially_____ Drinks per day:_____

For Insurance: I authorize the release of any medical or pertinent information necessary to process my claim. I authorize payment of medical benefits to Marie R. Levine OD. The Levine Eye Center's notice of privacy practices are available for your review. I understand that I am responsible for any charges not covered by my insurance plan

Signature:_____ Date:_____

(Parent if Patient is a Minor)