RUBIN EYE CENTER
PATIENT HISTORY INFORMATION

Today's Date: ____________________

NAME: ____ **DATE OF BIRTH:** ____/____/________
Address: ____ **Home Phone:** ____________________
City: ______________________________ **Zip:** __________ **Cell Phone:** ____________________
Parent/Guarantor (if minor): ____________________________ **OK to text?** ☐ **Yes** ☐ **No**

Gender: ☐**Male** ☐**Female** **Marital Status:** ☐**Single** ☐**Married** **Social Security Number (last 4 digits):** __________
Occupation: ______________________________**Employer:** ______________________________
Emergency Contact Name & Phone: ____

You may disclose my healthcare information to and discuss my healthcare needs with the following individual:
Name/phone of individual: ______________________________ Relationship: ____________________

Name/Phone of your PCP (primary care physician): ____________________________________
Email address: ______________________________(for access to an encrypted link to your records only)

In accordance with new federal healthcare legislation, we are required to obtain the following confidential information:
PREFERRED LANGUAGE: ☐English ☐Spanish ☐Other________________
RACE: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Hispanic ☐White
☐Native Hawaiian/Other Pacific Islander
ETHNICITY: ☐Hispanic or Latino ☐Native Hawaiian/Other Pacific Islander ☐Not Hispanic or Latino
COMMUNICATION PREFERENCE: ☐Telephone ☐Mail

Do you have any allergies to medications? What happens? ____________________________________
____

List all medications you take (prescribed and OTC eye drops, aspirin, etc):
____
____

Have you had surgery for any ocular injuries, Lasik or PRK, or cataract surgery: ______________________
____

Are you pregnant and/or nursing? ☐No ☐Yes (how many months?)__________

OCULAR HISTORY

Have you ever had any of the following: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, diabetic retinal complications, macular degeneration, detached retina, cataracts, eye infections, eye injuries, or other? Please circle and explain:
____
____

How long ago was your last eye exam? ____________________
Are you having any specific ocular issues today? ______________________________________
Do you wear glasses? If yes, how old is your present prescription? __________ Are you interested in trying contacts? __________
Do you currently wear contact lenses? If yes, are they specialty lenses such as toric, multifocal, or gas perms? ______________
List any problems you've had with contacts: ____
Do you have trouble seeing to drive, especially at night, or difficulty with reading or computer work? If yes, please describe:
____

Do you need safety or specialized eyewear for work (computer), sports, hobbies, etc? ______________________
____