BURGETT ♦ KRESOVSKY
EYE CARE

Jason M Burgett, MD
Seth P Kresovsky, MD

Patient Name: _____ Spouse/Parent Name: _____

Age: _____ Date of Birth: _____ Social Security Number: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Family Doctor: _____ Optometrist: _____

Employer Name: _____

Preferred Method of Communication: ☐ Phone ☐ Mail ☐ E-mail _____

Race: ☐ White ☐ African American/Black ☐ Asian ☐ Hispanic ☐ Other _____

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Sex: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Both ☐ Neither

Preferred Pharmacy: _____ Pharmacy Location: _____

In case of an emergency:

Contact _____ Relationship _____ Phone Number _____

OFFICE USE ONLY:

BURGETT ♦ KRESOVSKY
EYE CARE

ALLERGIES: ☐ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

EYE MEDICATIONS: ☐ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

EYE SURGERIES/DISEASES: ☐ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

OTHER SURGERIES: ☐ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICAL ILLNESSES:

1. Diabetes YES ☐ NO ☐
2. Heart Disease YES ☐ NO ☐
3. High Blood Pressure YES ☐ NO ☐
4. _____
5. _____
6. _____
7. _____
8. _____

CURRENT MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. Aspirin YES ☐ NO ☐
9. Coumadin YES ☐ NO ☐
10. Insulin YES ☐ NO ☐

FAMILY HISTORY:

Diabetes YES ☐ NO ☐
Cancer YES ☐ NO ☐
Heart Disease YES ☐ NO ☐
Stroke YES ☐ NO ☐
TB YES ☐ NO ☐
Kidney Disease YES ☐ NO ☐
Blindness YES ☐ NO ☐
Cataracts YES ☐ NO ☐

Glaucoma YES ☐ NO ☐
Macular Degeneration YES ☐ NO ☐
Retinal Disease YES ☐ NO ☐
High Blood Pressure YES ☐ NO ☐
Arthritis YES ☐ NO ☐
Lazy Eye YES ☐ NO ☐
Remarks:

SOCIAL HISTORY:

Smoking Status:
☐ Current Every Day Smoker
☐ Occasional Smoker
☐ Former Smoker
☐ Never Smoked

Do you drink alcohol? YES ☐ NO ☐
Drinks Per Day:
Do you use Illicit Drugs? YES ☐ NO ☐

BURGETT ♦ KRESOVSKY
EYE CARE

Do you currently have any problems in the following areas?

EYES	Y	N
Previous Surgery	☐	☐
Contact Lens	☐	☐
Pain	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Dry Eyes	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Lasik/RK	☐	☐
Retinal Detachment	☐	☐

EAR, NOSE, AND THROAT		
Hard of Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐

CARDIOVASCULAR		
Chest Pain	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Irregular Heart Beat	☐	☐
Difficulty Lying Flat	☐	☐

CONSTITUTIONAL		
Fatigue/Weakness	☐	☐
Fever	☐	☐
Weight Gain/Loss	☐	☐

RESPIRATORY	Y	N
Cough	☐	☐
Congestion	☐	☐
Wheezing	☐	☐
Asthma	☐	☐

GASTROINTESTINAL		
Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Jaundice/Hep	☐	☐

GENITO-URINARY		
Pain/Difficulty	☐	☐
Blood in Urine	☐	☐
Kidney Stones	☐	☐
History of STD	☐	☐

PSYCHIATRIC		
Anxiety/Depress	☐	☐
Mood Swings	☐	☐
Sleep Problems	☐	☐

ENDOCRINE		
Increased Thirst	☐	☐
Increased Hunger	☐	☐
Excess Urination	☐	☐
Increased Sweat	☐	☐
Fingernail Change	☐	☐

REMARKS: _____

_____

_____

_____

BLOOD/LYMPHATICS	Y	N
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Prolong Bleeding	☐	☐
Heavy Aspirin Use	☐	☐

MUSCULOSKELETAL		
Stiffness	☐	☐
Arthritis	☐	☐
Joint Pain/Swell	☐	☐

SKIN		
Rash/Sores	☐	☐
Lesions	☐	☐
Hives/Eczema	☐	☐

NEUROLOGICAL		
Seizures	☐	☐
Weakness/Paralysis	☐	☐
Numbness	☐	☐
Tremors	☐	☐

IMMUNOLOGIC		
Hives	☐	☐
Itching	☐	☐
Runny Nose	☐	☐
Sinus Pressure	☐	☐

Patient Signature: _____ **Date:** _____