JULIA D. MILANAK, O.D.
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Ph. (814)201-2423 Fax. (814)201-2444

Patient Name: _____ DOB: _____/_____/_____ SS#: _____/_____/_____

Patient Address: _____City_____State _____ Zip Code _____

Phone: _____ Cell: _____ Email: _____

What is your preferred method of contact regarding appointment reminders, order status notifications and other communications from our office? Telephone Text Message Email Other: _____

Current Employer: _____ Work Phone: _____

Occupation: _____

Do you currently have vision/medical insurance coverage? (Please CIRCLE): Yes No If yes, please present cards to staff.

Insurance Policy Holder: Self Spouse Parent Policy Holders Name: _____

Policy Holders DOB: ___/___/___ Marital Status: Married Single Divorced Widowed

Person Responsible for Bill (after insurance coverage): _____

Name of Medical Doctor: _____ Doctor's Phone: _____ Last Medical Exam: ____/____/____

How did you hear about our office (Please CIRCLE): Newspaper Yellow-pages Website Insurance Friend Referral

Other: _____If referred, whom may we thank: _____

Do you wear glasses? Y N If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? Y N If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? Y N

Do you have allergies to medications? Y N If yes, please explain: _____

_____

List any medications you take including dosages (including oral contraceptives, aspirin, over-the-counter medications and home remedies):_____

_____

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

_____

List any of the following that you have had: crossed eye, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

_____

Are you pregnant or nursing? Yes No

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No If yes, please describe:

_____

Do you use tobacco products? Yes No If yes, type / amount / how long: _____

Do you drink alcohol? Yes No If yes, type / amount / how long: _____

Do you use illegal drugs? Yes No If yes, type / amount / how long: _____

REVIEW OF SYSTEMS: Do you currently, or have you ever had any problems in the following areas?

SYSTEM	Yes	No	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain	☐	☐	☐
INTEGUMENTARY			
Skin	☐	☐	☐
NEUROLOGICAL			
Headache	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision / Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing / Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes / Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid / Other Glands	☐	☐	☐

EARS, NOSE, MOUTH, THROAT	Yes	No	?
Allergies / Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat / Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Cholesterol/Triglycerides	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals / Kidney / Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

FAMILY HISTORY (Please note any family members who have/had the following conditions.)

DISEASE / CONDITION	YES	NO	RELATIONSHIP TO YOU: PARENT / GRANDPARENT / SIBLING / CHILD
Blindness	☐	☐	
Cataract	☐	☐	
Crossed Eyes	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Retinal Detachment/Disease	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Kidney Disease	☐	☐	
Lupus	☐	☐	
Thyroid Disease	☐	☐	
Other _____	☐	☐	

_____ _____

Signature (Patient or Parent/Guardian) Date