

ARCHIBALD R. MORRIS, OD
ASHLEY M. MASTRINE, OD
JOSEPH J. OZBOLD, OD
125 Manor Drive Ebensburg, PA. 15931
814-472-9670

PATIENT DEMOGRAPHIC INFORMATION

Name: _____ Primary Care Physician: _____
Address: _____ Last Physical Exam: _____ Pharmacy: _____
Phone: _____ Cell: _____ Last Eye Exam: _____ Location: _____
E-mail: _____ Communication Preference: Phone Email Cell
Birth Date: _____ Gender: _____ Marital Status: _____

INSURANCE INFORMATION

Please provide information for medical and vision insurance.

Name of Insured: _____ Relationship to Patient: _____
Insured Social Security Number: _____ Insurance Company: _____

PATIENT MEDICAL HISTORY

Allergies: (Seasonal) _____ Immunologic: (Herpes, Lyme, TB) _____
Cardiovascular: (HTN, Chol, Stroke) _____ Integumentary: (Psoriasis, Rosacea) _____
Endocrine: (Thyroid, Diabetes) _____ A1C _____ Musculoskeletal: (Arthritis) _____
Gastrointestinal: (GERD) _____ Neurological: (Headache, Epilepsy, MS) _____
Genitourinary: (Bladder, STDs) _____ Psychiatric: (Anxiety, Depression) _____
Hematologic: (Leukemia, Clots) _____ Respiratory: (Asthma, COPD) _____
Systemic Surgeries: _____ Ocular Surgeries: _____
Medications: _____

Medication Allergies: _____

Tobacco Use: Never Former Quit _____ years Contact Lens Wearer: Yes No Glasses: Yes No
Alcohol Use: None Social Frequent Blood Transfusion: Yes No Narcotic Use: None Recreational Dependent

PATIENT FAMILY HISTORY

Please note family history and relation to the patient.

Blindness _____ Diabetes _____
Cataract _____ Heart Disease _____
Glaucoma _____ High Blood Pressure _____
Macular Degeneration _____ Thyroid Disease _____
Lazy Eye _____ Arthritis _____

Patient Signature _____ **Date** _____

Doctor Signature _____ **Date** _____