

**ARCHIBALD R. MORRIS, OD**  
**GIFFORD S. PIPER, OD**  
125 Manor Drive  
Ebensburg, PA. 15931  
814-472-9670

**PATIENT DEMOGRAPHIC INFORMATION**

Name: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
Address: \_\_\_\_\_ Last Physical Exam: \_\_\_\_\_ Pharmacy: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_ Location: \_\_\_\_\_  
Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Birth Date: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

Please provide information for medical and vision insurance.

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Insured Social Security Number: \_\_\_\_\_ Patient Social Security Number: \_\_\_\_\_  
Insured Birth Date: \_\_\_\_\_ 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 Quit \_\_\_\_\_ years Current \_\_\_\_\_ 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** \_\_\_\_\_