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** _____