GRIFFIN & REED
EYECARE
A MEDICAL CORPORATION

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Please Update Your Medical History

(please circle if you have ever had the following)

Today's Date:_____

Name_____

Last First MI

Street_____

City_____State___Zip_____

Date of Birth _____/_____/_____ Age_____ M / F

Single Married Divorced Drivers Lic# _____

SSN:_____

Email: _____

Primary Phone # ( )_____

Secondary phone # ( )_____

Employer _____

Address _____

City_____State___Zip_____

Parent's Name if not 18 _____

Mom Wk#_____

Dad Wk #_____

Emergency Contact _____

Relation_____Phone #_____

Vision Insurance

Insurance_____

SSN/ID#_____

Subscriber Name_____

Subscriber Date of Birth _____/_____/_____

Are you _Subscriber _Spouse _Dependant _Partner

Primary Major Medical Insurance

Insurance_____

SSN/ID#_____

Subscriber Name_____

Subscriber Date of Birth _____/_____/_____

Are you _Subscriber _Spouse _Dependant _Partner

Allergies: HayFever, Seasonal Allergies Contact Lens Solutions Eye Drop Allergies

Allergic to Medications Y N List meds_____

_____

_____

Respiratory Problems: Shortness of Breath Wheezing Coughing Asthma Emphysema

Gastrointestinal: Abdominal Pain Diarrhea Vomiting

Heart: Chest Pain Angina Irregular or Fast Heart Beat, High Cholesterol

Muscle / Skeletal: Arthritis Lupus Joint Pain Muscle Aches

Blood: High Blood Pressure HIV Aids

Nervous System: Hearing Problems Migraine Headaches Fainting Dizziness Stroke Paralysis Alzheimer Parkinson

Endocrine: Diabetes Thyroid Problems

Psychiatric: Depression Anxiety

Urology / GYN: Prostate problems Currently Pregnant

Cancer: _____

Primary Care Physician: _____

Current Medications:_____

_____

_____

_____

How did you hear of our practice? (click all that apply)
1- Internet 2- Pandora
3-Friend (name)_____
4- Radio (station) _____
5-Other _____
Which one prompted you to contact us today?

_____

Secondary Major Medical Insurance

Insurance_____

ID#_____

Subscriber Name_____

Subscriber Date of Birth _____/_____/_____

Are you _Subscriber _Spouse _Dependant _Partner