DANIEL T. LANTZ, O.D.

"We care for people, not just eyes."

Patient Information

Today's Date _____

First _____

Last _____

Middle Name _____

Nickname _____

PO Box _____ **Street** _____

City _____

State _____ **Zip Code** _____

Date of Birth _____

Gender: Male____ Female ____

Preferred Language (circle one):

English Spanish Japanese Other

Race (circle one):

White Asian Black Other

Ethnicity (circle one):

Hispanic Not Hispanic

Preferred Phone (circle one):

Home Work Cell

Home Phone _____

Work Phone _____

Cell Phone _____

E-mail _____

Medications

List below & include dosage (mg):

Or we can copy your list for you
Or we can call your pharmacy for a list

If you don't take any meds, please circle: NONE

Allergies

(List ***medical & environmental*** allergies):

Do you have a latex sensitivity?
No____ Yes____

Other

Pharmacy _____

Primary Care Physician _____

Do you have diabetes? No____ Yes____

If yes, which type? Type I ____ Type II ____
Year diagnosed? _____

Name _____ Date _____

Do you have or have you had any problems in the following areas? If "YES," please explain.

Review of Systems	NO	YES	Explain Problem:
General / Constitutional (cancer, fatigue syndrome, developmental disabilities, other)			
Ears, Nose, Throat (sinusitis, dry mouth, hearing loss, other)			
Neurological (migraine, tumor, stroke, epilepsy, MS, cerebral palsy, other)			
Psychiatric (depression, bipolar, attention deficit, anxiety, other)			
Cardiovascular (hypertension, congestive heart failure, vascular disease, heart disease, stroke, other)			
Respiratory (asthma, sleep apnea, emphysema, cigarette smoker, bronchitis, chronic obstruction, other)			
GI - (Gastro-Intestinal) (Crohn's disease, celiac disease, ulcer, colitis, other)			
GU - (Genital, Kidney, Bladder) (nursing, pregnant, benign prostate or cancerous prostate, kidney disease, STD, other)			
Muscles, Bones, Joints (muscular dystrophy, gout, ankylosing spondylitis, arthritis, fibromyalgia, other)			
Skin (rosacea, psoriasis, shingles, cold sores, eczema, other			
Endocrine (Type 1 Diabetes or Type 2 Diabetes, thyroid dysfunction, other)			
Blood/Lymph (large volume blood loss, hypercholesterolemia, anemia, other)			
Allergy/Immune System (environmental allergies, Sjogrens, rheumatoid arthritis, drug allergies, lupus, other)			

Social History

Do you drink alcohol? No____ Yes____
(If yes, circle one):
occasionally 1/day 2-3/day 4+day

Do you use tobacco? No____ Yes____
(If yes, circle all that apply):
cigarettes cigars pipe smokeless tobacco
How much _____
Smoking Status- (circle one):
smoker former smoker never smoked status unknown

Do you have any hobbies or special vision needs?
(computer, sports, sewing, reading, etc.)
No____
Yes_____

Past Ocular History

Do you have or have you ever had...
(Circle all that apply):

Injury	Retinal Detachment
	Retinal Degeneration
Keratoconus	Retinal Hole
Nystagmus	Glaucoma
Dry Eye	Inflammatory Disorder
Cataract	Strabismus
Age-Related Macular Degeneration	Amblyopia
Patching	None of the Above

Previous Eye Surgeries _____
_____
Previous Eye Injuries _____
_____
Other Eye Conditions _____
_____

Family History

List family members who have had the following conditions

PLEASE SPECIFY:
Mother, Father, Sibling, Children

High Blood Pressure –

Diabetes –

Macula Degeneration –

Glaucoma -