ANWAR EYE CENTER

New Patient Information Sheet

APPOINTMENT DATE:_____

PATIENT'S FULL NAME: _____ _____ _____

AGE:_____ **DATE OF BIRTH:**_____ **SEX:** ___**M** ___**F**

ADDRESS:_____

ZIP CODE_____

HOME NUMBER ( )_____ **ADDITIONAL #( )** _____
CELL NUMBER ( )_____

Patient's occupation & place of employment_____

Marital Status: _____Single _____Married _____Separated

_____Divorced _____Widowed

SOCIAL SECURITY NUMBER:_____-_____-_____

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Social Sec. # _____-_____-_____ Date of Birth: _____

Medical Insurance: Primary:_____ Secondary:_____

ID Number:_____ ID Number:_____

Have you ever had a general anesthetic? (YES)_____ (NO)_____

IF YES, Did you have any complications?_____
Do you wear glasses?_____ At what age did you get your first pair?_____

CHIEF VISUAL COMPLAINT : _____

NAME AND ADDRESS OF NEXT OF KIN:_____
_____ Phone ( )_____
Have you ever been treated in this office before? _____
If yes, when? _____

***PLEASE BRING A PHOTO ID & INSURANCE CARD(S)** *

ANWAR EYE CENTER

DISCLOSURE OF PHYSICIAN OWNERSHIP

Please carefully review the information contained in this notice.

1. Anwar Eye Center meets the definition of a "physician-owned ambulatory surgery center" under 42 Code of Federal Regulations §416. The ambulatory surgery center is owned in part by the following physicians.

   M.F. Anwar, MD

2. You have the right to choose the provider of your health care services. Although we believe that Anwar Eye Center will be able to meet your needs, you have the option to use a facility other than Anwar Eye Center. You will not be treated differently by your physician if you choose to use a different facility; however, your physician may not be able to perform your procedures at an alternative facility if he does not maintain privileges at such facility. If desired, your physician or any staff member can provide information about alternative health care providers.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Anwar Eye Center. We welcome you as a patient and value our relationship with you.

Signing below means that you have received and understand this notice.

Signature:	Date:

HISTORY EVALUATION

NAME: _____ AGE: _____ TODAY'S DATE: _____

FAMILY PHYSICIAN _____ CITY/STATE _____

Do you have problems with the following?:	YES	NO	COMMENTS
CONSTITUTIONAL SYMPTOMS			
FEVER			
WEIGHT LOSS			
OTHER			
EARS, NOSE AND THROAT			
SINUS CONGENSTION			
RUNNY NOSE			
POS-NASAL DRIP			
CHRONIC COUGH			
DRY THROAT/MOUTH			
CARDIOVASCULAR			
CAROTID ARTERY DISEASE			
HEART DISEASE			
ANGINA			
IRREGULAR HEART			
RHEUMATIC FEVER			
CONGESTIVE HEART FAILURE			
HIGH BLOOD PRESSURE			
STROKE			
HEMATOLOGIC/LYMPHATIC			
BLEEDING PROBLEMS			
BLOOD THINNERS			
ANEMIA			
PHLEBITIS			
ALLERGIC/IMMUNOLOGIC			
SEASONAL ALLERGIES			
HAY FEVER SYMPTOMS			

	YES	NO
RESPIRATORY (LUNGS/BREATHING)		
PNEUMONIA		
BRONCHITIS		
TUBERCULOSIS		
EMPHYSEMA		
ASTHMA		
GASTROINTESTINAL (STOMACH/INTESTINE)		
HIATAL HERNIA		
ULCERS		
DIVERTICULOSIS		
GENITOURINARY (GENITALS/KIDNEY/BLADDER)		
KIDNEY DISEASE		
SEXUALLY TRANSMITTED DISEASE		
MUSCLES, BONES, JOINTS		
ARTHRITIS		
INTEGUMENTARY (SKIN AND/OR BREAST)		
SKIN DISEASES		
NEUROLOGICAL		
HEADACHES		
HEAD INJURY		
TREMORS		
SEIZURES		
PSYCHIATRIC		
CLAUSTROPHOBIA		
ENDOCRINE		
DIABETES		
LIVER DISEASE		
THYROID		

HOSPITALIZATIONS:

YES	NO		YES	NO		YES	NO	
____	____	HEART SURGERY	____	____	MASTECTOMY	____	____	BACK
____	____	GALLBLADDER	____	____	THYROID	____	____	CANCER
____	____	HYSTERECTOMY	____	____	APPENDECTOMY	____	____	OTHER
____	____	PROSTATE	____	____	HERNIA			
					HEPATITIS	____	____	HIV

	YES	NO
	____	____

PRESENT MEDICATIONS AND DOSAGES:

ALLERGIES TO MEDICATIONS:

PATIENT'S NAME: _____

FAMILY HISTORY: RELATIVES LIVING?	YES	NO	MEDICAL PROBLEMS/CAUSE OF DEATH
MOTHER	____	____	_____
FATHER	____	____	_____
GRANDPARENTS	____	____	_____
BROTHERS/SISTERS	____	____	_____
CHILDREN	____	____	_____

SOCIAL HISTORY

CURRENT OCCUPATION: _____

LIVING ARRANGEMENTS: _____

MARITAL STATUS (Married, Divorced, Single, Widowed): _____

DO YOU SMOKE? _____ HOW MUCH? _____

DID YOU SMOKE? _____ HOW LONG? _____

DO YOU DRINK? _____ HOW MUCH? _____

PATIENT'S, DO NOT WRITE BELOW THIS LINE

UPDATED

DATE: _____
INITIAL: _____
INFO: _____

UPDATED

DATE: _____
INITIAL: _____
INFO: _____

UPDATED

DATE: _____
INITIAL: _____
INFO: _____

UPDATED

DATE: _____
INITIAL: _____
INFO: _____

UPDATED

DATE: _____
INITIAL: _____
INFO: _____

UPDATED

DATE: _____
INITIAL: _____
INFO: _____

UPDATED

DATE: _____
INITIAL: _____
INFO: _____

UPDATED

DATE: _____
INITIAL: _____
INFO: _____