Joseph M. Williams, M.D., Ph. D.

PATIENT REGISTRATION

Name: _____ Date of birth: _____

Address: _____ City: _____ State:_____ Zip: _____

Tel. Home: _____ Work: _____ Cell: _____

Marital Status:_____ Male: _____ Female _____

Email Address:

_____

Race: (Please Circle) American Indian; Alaskan Native; Asian; Black or African American;
Native Hawaiian or Other Pacific Islander; White

Ethnicity: (Please Circle) Hispanic or Latino; Non-Hispanic/Non-Latino

Emergency Contact: _____ Phone #:_____

Relationship: _____

Primary Care Physician:

Name:_____

Address:_____

Who may we thank for referring you:

Name: _____

Address: _____

I hereby authorize Joseph M. Williams, M.D. to administer such treatment as may be deemed necessary or advisable in the care of:

_____

Guardian's Signature: _____ Relationship:_____

ALL PATIENTS

I authorize the release of any payment and medical information necessary to process this and any related claims.
I certify that the above information is correct.

Signature:_____ Date_____

Medical History Questionnaire

Name _____ **Date** _____

Date of **Birth** _____ Date of **last eye exam** _____

List any **medications** you currently take (Rx and over-the-counter): _____

_____

Do you have **allergies** to any medications? **YES** **NO**
If YES, list the medications: _____

_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.): _____

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you currently have any problems in the following areas? If YES, please provide additional information.

	YES	NO	DETAILS
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)
Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO

Have you ever had a blood transfusion? YES NO

Do you drink alcohol? YES NO If YES, how much? _____

Do you smoke? YES NO If YES, how much? _____ How many years? _____

ACKNOWLEDGMENT

I, _____, acknowledge that I may have a copy of The HIPPA Notice of Privacy Practices for Joseph William, M.D. and Arinella-Williams, LLC upon request.

Date:_____ Signed: _____