Richard J. Lasonde, MD Jill Federico, OD Naila Aslam, OD

155 Griffin Rd Portsmouth, NH 03801 603-430-5225



PATIENT HISTORY

	Plea	ase Print]	DATE		
MR / MRS / MS	DATE OF BIRTH				
ADDRESS		CITY	STATEZIP		
MAILING ADDRESS	(If different)				
CITY	STATE	ZIP			
HOME PHONE (_)	WORK PHONE ()		
			<u>@</u>		
	#				
EMERGENCY CONT	ACT	PHONE ()		
EMPLOYER	OCCUPATION				
PRIMARY PHYSICIA	NPHONE ()				
OPTOMETRIST	CITY:				
	PHONE ()				
Questions r	elating to the Patient Pro	otection and Afforda	ble Care Act (ACA) 2010:		
PREFERRED LANGU	AGE:				
ETHNICITY: Hisp	panic or Latino Not His	spanic or Latino D	ecline to answer Unknown		
RACE American Indian Alaska Native Asian Black or African American Native Hawaiian Other Pacific Islander White Decline to answer Unknown					
INSURANCE:	1	2			
MARITAL STATUS:	SINGLE / MARRIED	D / WIDOWED /	DIVORCED		
SPOUSE / NEXT OF K	KINPHONE				
HOW DID YOU HEA	R ABOUT US?				
INDIVIDUAL:		DOCTOR:			
	KQ WHEB WQS				

PAST MEDICAL HISTORY			
Please CHECK if you now have or			When the incident occurred or
have ever had any of the following:			when the condition was diagnosed
have ever had any of the following.	YES	NO	when the condition was diagnosed
DIABETES	1123	110	
HIGH BLOOD PRESSURE			
ASTHMA			
COPD / EMPHYSEMA			
HEART ATTACK			
ANGINA			
BLEEDING DISORDER			
G.I. DISEASE			
LIVER DISEASE / HEPATITIS			
KIDNEY DISEASE / STONES			
PERIPHERAL VASC DISEASE			
TUBERCULOSIS			
IRREGULAR HEART BEAT			
CARDIAC PACEMAKER			
STROKE			
ANEMIA			
HAYFEVER			
BRONCHITIS			
PNEUMONIA			
STOMACH ULCER			
ARTHRITIS			
CANCER OR TUMOR –LOCATION			
and TREATMENT			
THYROID DISEASE			
SEIZURES			
VARICOSE VEINS /LEG BLOOD CLOTS			
HIV, AIDS, Other Blood Disorders			
·			
Family and Social History			
Among your Blood Relatives, are there any of t	the follow	ving: Re	elative (s):
YES	NO		
GLAUCOMA			
CATARACTS			
MACULAR DEGENERATION			
OTHER RETINAL DISEASES			
COLOR BLINDNESS			
UNEXPLAINED VISUAL LOSS			
BLINDNESS			
D (O I III)			
Past Ocular History (Past Eye History)			
Have you had or been diagnosed with any of the			
Eye Trauma – Type: wh	nen:		
Cataracts			
Recurrent Corneal Erosion			
Keratoconus			
Allergic Conjunctivitis			
Glaucoma			
Corneal Ulcers			
Iritis			
Herpes Keratitis (Eye Condition)			
Dry Eye Syndrome			
Corneal Scars			
Lazy or Crossed Eye(s)			

<u>Previous Eye Surgeries (please list the eINDICATE IF NONE</u>	eye and approximately when the	ne surgery occurred) PLEASE
1. 2.		
<u>J</u>		
<u>4.</u> <u>5.</u>		
	MS: DO YOU HAVE THE OPRIATE SYMPTOM YOU AI	
Cardiovascular: chest pain, irregular heart b	eat, shortness of breath	
Ear /Nose/ Throat Problems: dizziness, hear	ring loss, hoarseness, ringing in ear	s, sore throat
Neurological: balance problems, headache, n	umbness, tingling	
Constitutional: fatigue, fever, night sweats, w	veakness, weight loss	
Hematologic: bleeding, bruising, tender nodes	S	
Psychiatric: anxiety, depression, insomnia, irr	ritability, nervousness	
Gastrointestinal: abdominal pain, constipation	on, heartburn, nausea, vomiting	
Metabolic: cold intolerance, excess hunger, e	excessive thirst, frequent urination,	heat intolerance
Respiratory: cough, trouble breathing, wheez	ing	
Genitourinary: genital discharge, genital lesion	ons, painful urination, urgency	
Musculoskeletal: back pain, joint pain, muscl	le pain, stiffness, swelling	
Skin: hair loss, rash, skin lesions		
WHAT MEDICATIONS DO YOU TAKE F	REGULARLY? PLEASE INDICA	TE IF NONE
NAME	DOSAGE	TIMES DAILY
12		
3		
4		
5 6		
7		
ANY EYE DROPS OR EYE MEDS? <i>PL</i>		
1		
3		
4		
5		

1. 2. 3. 4. 5. 5. 6. ALLERGIES: SOCIAL HISTORY: PLEASE CIRCLE THE APPROPRIATE ANSWER SMOKING:	PREVIOUS SURGERIES:		YEAR:
2. 3. 4. 5. 6. ALLERGIES: PLEASE CIRCLE THE APPROPRIATE ANSWER SMOKING: ALCOHOL: RECREATIONAL DRUGS: 1. Current Everyday Smoker 2. Rarely 2. Rarely 3. Former Smoker 3. Occasional 4. Never Smoked 4. Daily 5. Frequent 6. Heavy 6. Heavy 7. Frequent 6. Heavy 6. Heavy 7. Pipe of Tobacco: Type of Alcohol: Type of Drug: Amphetamine Cigarettes Cigar Beer Amphetamine Cigarettes Liquor Cocaine Pipe Wine IV drugs, LSD OCCUPATION: HOBBIES: Business Computer Manual Labor Music Office work Sewing Retired Sports Student Travel I hereby authorize and direct the above-named insurance company to pay benefits directly to Northeast Corneal Consultants, PA (dabe Excellent Vision Eye and Laser Centers). I further authorize this office, Excellent Vision Eye and Laser Centers). I further authorize this office, Excellent Vision Eye and Laser Centers). I further authorize this office, Excellent Vision Eye and Laser Centers). I further authorize this office, Corneal Consultants, PA (dabe Excellent Vision Eye and Laser Centers). I further authorize this office, Excellent Vision Eye and Laser Centers). I further authorize this office, Excellent Vision Eye and Laser Centers). I further authorize this office, Excellent Vision Eye and Laser Centers). I further authorize this office, Excellent Vision Eye and Laser Centers, I further authorize this office, Excellent Vision Eye and Laser Centers, I further authorize this office, Excellent Vision Eye and Laser Centers, I further authorize this office, Excellent Vision Eye and Laser Centers, I further authorize this office, Excellent Vision Eye and Laser Centers, I further authorize this office, Excellent Vision Eye and Laser Centers, I further authorize this office, Excellent Vision Eye and Laser Centers, I further authorize this office, Excellent Vision Eye and Laser Centers, I further authorize this office, Excellent Vision Eye and Laser Centers, I further authorize this office, Excellent Vision Eye and Laser Centers, I further authorize this office, Excellent Vision Eye and Laser Centers,	•		
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4. Never Smoked 4. Daily 5. Frequent 6. Heavy 6. Heavy 7. Type of Tobacco: Cigar Cigar Beer Cigarettes Liquor Cocaine Pipe Wine Type of Molechol: Type of Drug: Amphetamine Cocaine Pipe Wine Cocaine Pipe COCUPATION: HOBBIES: Business Computer Manual Labor Music Office work Sewing Retired Sports Student Travel I hereby authorize and direct the above-named insurance company to pay benefits directly to Northeast Corneal Consultants, PA (dba Excellent Vision Eye and Laser Centers). I further authorize this office, Excellent Vision Eye and Laser Centers, to release to the above-named insurance company any medical information necessary to obtain payment for my treatment. I understand my insurance company will be billed on my behalf and I am responsible for all fees, deductibles, co-payments, and any unpaid portion of my bill. I certify the above information is true and correct to the best of my knowledge and will notify Excellent Vision Eye and Laser Centers of any changes of the above stated information. Should this account go delinquent, you may be responsible for all additional fees, collection fees, attorney fees, court costs, and administration fees.	3. Former Smoker	3 Occasional	▼
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