Tracey L. Mercer, O.D., P.C. 2000 Southlake Park Suite 100 Hoover, AL 35244

Patient Information / History

Name	Date		
Address	Phone		
City State Zip	Work/Cell		
DOB / / Age Gender	ale SS# / /		
Marital Status: (Circle One) Single Married Divorced	Widowed		
Language, Race, Ethnicity			
Employer/School Occupat	tion/Grade		
Email			
How did you hear about our office? ☐ Insurance Company			
☐ Personal Referral: Name	🗆 Other		
Person in Charge of Account			
Emergency Contact Information: Name			
INSURANCE INFORMATION			
Vision Insurance			
Insurance Company			
Policyholder's Name			
Contract # or SS# of Policyholder	-		
Medical Insurance			
Insurance Company			
Policyholder's Name	DOB		
Contract # Group #			
MEDICAL HISTORY			
Primary Care Physician			
Physician Phone # Date of	last physical exam		
Current medications (including over-the-counter meds)			
Allergies to medications			
Pharmacy Phar	Pharmacy Phone		
Height Weight			
Major surgeries or hospitalizations			
Are you pregnant? Nursing?			
Date of last eye exam Doctor s	Doctor seen		
Do you wear glasses? If yes, how old is current pair	r? Bifocals/Trifocals/Progressive (please circle)		
Do you wear contacts? Brand	· · · · · · · · · · · · · · · · · · ·		
Reason for today's visit Brand			
neason for coddy 5 visit			

Hobbies	OTHER			
Do you use tobacco?				
Do you drink alcohol?	Do you use tobacco?	If yes, type,	amount/how long?	
Circle any of the following ocular problems you experience Loss of Vision Dryness Redness Mucous Discharge Itching Excessive Watering Styes Flashes/Floaters Double Vision REVIEW OF SYSTEMS – Are you currently experiencing any of the following problems? Yourself Family Member COLULAR HISTORY Blindness Since no Glaucoma Macular Degeneration Lazy/Crossed Eye Yes no ALLERGIC VASCULAR/CARDIOVASCULAR Stroke High blood pressure Yes no Vascular disease Yes no CONSTITUTIONAL Fever, weight loss/gain Weakness/dizziness Yes no ENDOCRINE Thyroid/other glands Lyes no GASTROINTESTINAL Acid reflux Other GI disorder Yes no Sexually transmitted disease Yes no Sexually transmitted disease Yes no Dental disease Yes no Descandar Yes no Distorted Vision Distorted Vision Poreled Vision P				
Loss of Vision Dryness Redness Mucous Discharge Glare/Light Sensitivity Itching Burning Eye Pain Foreign Body Sensation Excessive Watering Styes Flashes/Floaters Double Vision REVIEW OF SYSTEMS – Are you currently experiencing any of the following problems? Yourself Family Member	Do you use illegal drugs?	If yes, type/	amount/how long?	
Loss of Vision Dryness Redness Mucous Discharge Glare/Light Sensitivity Itching Burning Eye Pain Foreign Body Sensation Excessive Watering Styes Flashes/Floaters Double Vision REVIEW OF SYSTEMS – Are you currently experiencing any of the following problems? Yourself Family Member				
Dryness Redness Burning Eye Pain Foreign Body Sensation	Circle any of the following oc	ular problems you ex	perience	
Itching Excessive Watering Styes Floaters Double Vision REVIEW OF SYSTEMS – Are you currently experiencing any of the following problems? Vourself Family Member	Loss of Vision	Blurred Vision	Distorted Vision	Loss of Side Vision
Excessive Watering	Dryness	Redness	Mucous Discharge	Glare/Light Sensitivity
Yourself Family Member	Itching	Burning	Eye Pain	Foreign Body Sensation
Yourself Family Member	Excessive Watering	Styes	Flashes/Floaters	Double Vision
Yourself Family Member	DEVIEW OF SYSTEMS AROUS	ou currently evection	sing any of the following	na nrohlomo?
OCULAR HISTORY Blindness	REVIEW OF STSTEIVIS - Are yo	ou currently experier	icing any or the ronown	ig bronieinis:
OCULAR HISTORY Blindness		Yourself	Family Men	nber
Blindness yes no Cataract yes no Glaucoma yes no Macular Degeneration yes no Degeneration yes yes no Degeneration yes yes yes yes yes yes	OCULAR HISTORY		, ,	
Cataract		□ ves □ no		
Glaucoma		•		
Macular Degeneration		•		
Lazy/Crossed Eye		•		
ALLERGIC yes no	_			
VASCULAR/CARDIOVASCULAR Stroke	Lazy/Crossed Eye			
VASCULAR/CARDIOVASCULAR Stroke	ALLERGIC	□ves□no		
Stroke	ALLENGIC	□ yes □ no		· · · · · · · · · · · · · · · · · · ·
High blood pressure	VASCULAR/CARDIOVASCULAR	₹		
Vascular disease	Stroke	\square yes \square no		
CONSTITUTIONAL Fever, weight loss/gain yes no Weakness/dizziness yes yes no Weakness/dizziness yes	High blood pressure	\square yes \square no		
Fever, weight loss/gain	Vascular disease	□ yes □ no		
Fever, weight loss/gain	CONCENTIALIZADA			
Weakness/dizziness				
ENDOCRINE Thyroid/other glands yes no		•		
Thyroid/other glands	Weakness/dizziness	□ yes □ no		
Thyroid/other glands	ENDOCRINE			
Diabetes		□ ves □ no		
Lupus		•		
GASTROINTESTINAL Acid reflux		•		· · · · · · · · · · · · · · · · · · ·
Acid reflux	Lapas	_ yes _ ne		
Other GI disorder	GASTROINTESTINAL			
GENITOURINARY Genitals/kidneys/bladder yes no Sexually transmitted disease yes no EARS, NOSE, MOUTH, THROAT Sinusitis yes no Dental disease yes no	Acid reflux	\square yes \square no		
Genitals/kidneys/bladder yes no Sexually transmitted disease yes no EARS, NOSE, MOUTH, THROAT Sinusitis yes no Dental disease yes no	Other GI disorder	\square yes \square no		
Genitals/kidneys/bladder yes no Sexually transmitted disease yes no EARS, NOSE, MOUTH, THROAT Sinusitis yes no Dental disease yes no	GENITOLIRINARY			
Sexually transmitted disease yes no EARS, NOSE, MOUTH, THROAT Sinusitis yes no Dental disease yes no		or a voc a no		
EARS, NOSE, MOUTH, THROAT Sinusitis	•	•		
Sinusitis	Sexually transmitted diseas	e ⊔ yes ⊔ no		
Dental disease ☐ yes ☐ no	EARS, NOSE, MOUTH, THROA	Т		
Dental disease	Sinusitis	□ yes □ no		
,	Dental disease	•		
	Ear infections	, □ yes □ no		

	Yourself	Family Member
LYMPHATIC/HEMATOLOGIC		
Anemia	□ yes □ no	
Bleeding problems	□ yes □ no	
IMMUNOLOGIC		
HIV	□ yes □ no	
Other immune problems	•	
INTEGUMENTARY (skin)		
Eczema	□ yes □ no	
BONES/JOINTS/MUSCLES		
Arthritis	□ yes □ no	
Scoliosis	, □ yes □ no	
Myasthenia Gravis	yes □ no	
NEUROLOGICAL		
Headaches	□ yes □ no	
Migraines	□ yes □ no	
Seizures	□ yes □ no	
D01/01114-TD10	•	
PSYCHIATRIC	□ yes □ no	
RESPIRATORY		
Asthma	\square yes \square no	
Chronic bronchitis	□ yes □ no	
COPD	□ yes □ no	