Tammy J. Panner, O.D.
Joanna L. Wen, O.D.

Patient's Name: Mr./Mrs./Ms._____ Today's Date _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ Cell Phone_____
Date of Birth _____ E-mail address _____
Employer _____ Work Phone_____
Occupation _____

Updated Review of Systems
Do **you** have a history of any of the following conditions (common examples in parentheses):

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Eye Disease
- ☐ Eye Surgery
- ☐ Eye Injury
- ☐ Lazy eye
- ☐ Eye Turn
- ☐ Double vision
- ☐ HIV+ or AIDS
- ☐ Blood disorders (anemia)
- ☐ Respiratory (asthma)
- ☐ Constitutional (faint/dizzy)
- ☐ Psychiatric (depression)
- ☐ Cardiovascular (high blood pressure, heart/ vessel disease, cholesterol)
- ☐ Skin conditions (rosacea, excema)
- ☐ Gastrointestinal (Crohn's, colitis)
- ☐ Genitourinary (kidney, bladder)
- ☐ Endocrine (diabetes, thyroid)
- ☐ Neurological (headaches)
- ☐ Ear/Nose/Throat (sinus/ears)
- ☐ Musculoskeletal (fibromyalgia, rheumatoid arthritis)
- ☐ **None of the Above**

Specifics of above or other medical conditions _____
_____

Are you presently taking any medications (including oral contraceptives)? ☐ Yes ☐ No
If yes, please list which ones and for what purpose.
_____
_____

Allergic to: ☐ Pollen, molds, dust, etc. ☐ Latex rubber ☐ Medications ☐ None
What medications? _____

Date of last general health exam _____ Physician _____
Major Medical Insurance _____
Do you need a referral from your primary care physician for specialty care? ☐ Yes ☐ No

I hereby authorize any necessary medical treatment rendered by Drs. Panner or Wen. I understand that payment for such services is expected when services are rendered, and I agree to be responsible for my bill and any collection fees necessary to collect such payment. I also understand that preauthorization of coverage does not guarantee payment by my insurance company, and I agree to assume all financial responsibility for balances not paid by my insurance company within ninety days of submission of claims. I also authorize this office to release any information necessary to expedite my insurance claims.

_____ _____
Signature of Patient/Parent Date
(If a minor, Parent or Guardian must sign)