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 ☐ Male ☐ Female SS# _____/_____/_____
Marital Status: (Circle One) Single Married Divorced Widowed
Language, Race, Ethnicity _____
Employer/School _____ Occupation/Grade _____
Email _____
How did you hear about our office? ☐ Insurance Company ☐ Advertisement
☐ Personal Referral: Name _____ ☐ Other _____
Person in Charge of Account _____ Relationship _____
Emergency Contact Information: Name _____ Phone Number _____

INSURANCE INFORMATION

Vision Insurance

Insurance Company _____
Policyholder's Name _____ DOB _____
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 _____ Pharmacy Phone _____
Height _____ Weight _____
Major surgeries or hospitalizations _____
Are you pregnant? _____ Nursing? _____ Due date if pregnant _____
Date of last eye exam _____ Doctor seen _____
Do you wear glasses? _____ If yes, how old is current pair? _____ Bifocals/Trifocals/Progressive (please circle)
Do you wear contacts? _____ Brand _____ Do you sleep in them? _____
Reason for today's visit _____
_____

OTHER

Hobbies _____ Computer Use? _____ Hours/day _____

Do you use tobacco? _____ If yes, type/amount/how long? _____

Do you drink alcohol? _____ If yes, type/amount/how long? _____

Do you use illegal drugs? _____ If yes, type/amount/how long? _____

Circle any of the following ocular problems you experience

Loss of Vision	Blurred Vision	Distorted Vision	Loss of Side 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**
OCULAR HISTORY		
Blindness	☐ yes ☐ no	_____
Cataract	☐ yes ☐ no	_____
Glaucoma	☐ yes ☐ no	_____
Macular Degeneration	☐ yes ☐ no	_____
Lazy/Crossed Eye	☐ yes ☐ no	_____
ALLERGIC	☐ yes ☐ no	_____
VASCULAR/CARDIOVASCULAR		
Stroke	☐ yes ☐ no	_____
High blood pressure	☐ yes ☐ no	_____
Vascular disease	☐ yes ☐ no	_____
CONSTITUTIONAL		
Fever, weight loss/gain	☐ yes ☐ no	_____
Weakness/dizziness	☐ yes ☐ no	_____
ENDOCRINE		
Thyroid/other glands	☐ yes ☐ no	_____
Diabetes	☐ yes ☐ no	_____
Lupus	☐ yes ☐ no	_____
GASTROINTESTINAL		
Acid reflux	☐ yes ☐ no	_____
Other GI disorder	☐ yes ☐ no	_____
GENITOURINARY		
Genitals/kidneys/bladder	☐ yes ☐ no	_____
Sexually transmitted disease	☐ yes ☐ no	_____
EARS, NOSE, MOUTH, THROAT		
Sinusitis	☐ yes ☐ no	_____
Dental disease	☐ yes ☐ no	_____
Ear infections	☐ yes ☐ no	_____

	Yourself	Family Member
LYMPHATIC/HEMATOLOGIC		
Anemia	☐ yes ☐ no	_____
Bleeding problems	☐ yes ☐ no	_____
IMMUNOLOGIC		
HIV	☐ yes ☐ no	_____
Other immune problems	☐ yes ☐ no	_____
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	_____
PSYCHIATRIC	☐ yes ☐ no	_____
RESPIRATORY		
Asthma	☐ yes ☐ no	_____
Chronic bronchitis	☐ yes ☐ no	_____
COPD	☐ yes ☐ no	_____