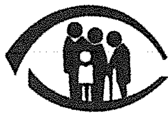

Hopping Eye Associates, Ltd, LLP

Ronald L. Hopping, OD, FAAO
Desiree T. Hopping, OD, FAAO
Reed A. Hopping, OD
Vissett S. Sun, OD, FAAO
J. Martin Prati, OD, FAAO

Date ________________

Thank you for completing this form and allowing us to take better care of you.

Name ______________________________ Date of birth __________

Personal History:

Do you use tobacco products? Y N
If yes, type/amount/how long ______________________________
Do you drink alcohol? Y N
If yes, type/amount/how long ______________________________

Family History:
Please note any family members, living or deceased, who had the following:

			Relationship:	Maternal/Paternal:
Arthritis	Y	N	_______	M / P
Cancer	Y	N	_______	M / P
Diabetes	Y	N	_______	M / P
Heart disease	Y	N	_______	M / P
High blood pressure	Y	N	_______	M / P
Kidney disease	Y	N	_______	M / P
Thyroid disease	Y	N	_______	M / P

Other ______________________________

Do you currently, or ever had, problems with the following:

SYSTEM			comments
CONSTITUTIONAL	**Y**	**N**	________
Recent fever, weight loss/gain	Y	N	________
INTEGUMENTARY (Skin)	**Y**	**N**	________
NEUROLOGICAL	**Y**	**N**	________
Headaches	Y	N	________
Migraines	Y	N	________
Seizures	Y	N	________
ENDOCRINE	**Y**	**N**	________
Thyroid/other glands	Y	N	________
EAR/NOSE/MOUTH/THROAT	**Y**	**N**	________
Allergies/hay fever	Y	N	________
Sinus congestion	Y	N	________
Runny nose	Y	N	________
Post Nasal Drip	Y	N	________
Chronic cough	Y	N	________
Dry throat / mouth	Y	N	________
ALLERGIC / IMMUNOLOGIC	**Y**	**N**	________
LYMPHATIC / HEMATOLOGIC	**Y**	**N**	________
Anemia	Y	N	________
Bleeding problems	Y	N	________

			comments
RESPIRATORY	**Y**	**N**	________
Asthma	Y	N	________
Chronic bronchitis	Y	N	________
Emphysema	Y	N	________
VASCULAR / CARDIOVASCULAR	**Y**	**N**	________
Diabetes	Y	N	________
Heart pain/disease	Y	N	________
High blood pressure	Y	N	________
Vascular disease	Y	N	________
Hypercholesterol	Y	N	________
GASTROINTESTINAL	**Y**	**N**	________
Diarrhea	Y	N	________
Constipation	Y	N	________
GENITOURINARY	**Y**	**N**	________
Genitals/kidney/bladder	Y	N	________
Rheumatoid arthritis	Y	N	________
Muscle pain	Y	N	________
Joint pain	Y	N	________
Current pregnancy	Y	N	________
PSYCHIATRIC / NERVES	**Y**	**N**	________

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies)

____

____

Do you have any allergies to any medications? (circle one) Yes No If yes, list______________________________

If you have a condition not listed, please explain and list medications:

____

____

Patient Signature: ______________________ Date: ______________