naba

Northeastern Association
of the Blind at Albany

Name: _____
DOB: _____ Exam Date: _____

Occupation: _____ Employer: _____
Address: _____
City: _____ State: ____ Zip:_____
Cell phone: _____ Work Phone: _____
Home phone: _____
Email: _____

Emergency Contact: _____
Relationship to Patient: _____
Contact Address: _____
Contact Phone number: _____

Primary Insurance Company
- Company Name: _____
- Policy #: _____
- Group #: _____

Secondary Insurance
- Company Name: _____
- Policy #: _____
- Group #: _____

Please bring insurance cards to your appointment so we can photocopy them. All copays will be expected to be paid the day of your appointment.

Primary Care Physician: _____
Last Visit Date: _____

Current Eye Doctor(s): _____
_____
Last Appointment: _____
Next Appointment: _____

Name: _____
DOB: _____ Exam Date: _____

Reason for Today's Appointment and Current Eye Condition(s):
_____
_____

Do you currently wear glasses? Y N
If Yes, how old are your glasses? _____
Are your glasses helpful? Y N
Do you currently use any magnifiers? Y N
If Yes, where are they from? _____
Are your magnifiers helpful? Y N

Please bring all current glasses
and
magnifiers to your appointment.

Do you have problems with or take medication for any of the following:

Ears, Nose, Throat? Y N
Heart, High Blood pressure, High Cholesterol? Y N
Breathing problems (Asthma, COPD, …)? Y N
Endocrine (Diabetes, Thyroid, …)? Y N

Nerve problems (Neuropathy, Tremors, …)? Y N
Muscle/Bone problems (Arthritis, Muscle/Joint Pain)? Y N
Depression, Anxiety, Insomnia (Mental Health Issues)? Y N
Headaches? Y N
Stomach, intestines, reflux? Y N
Stroke or TBI? Y N
Please list all other medical health problems: _____

_____

_____

_____

_____

_____

Name: _____
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Please list all medications you are taking or provide a separate list:_____

_____

_____

_____

Please list any allergies you may have: _____

_____

Do you or Did you smoke tobacco? Y N
How many per day? _____
How long ago did you quit? _____
Do you still drive? Y N
If Yes, do you still drive at night? Y N
Do you have trouble seeing road signs? Y N
Do you have trouble seeing your dashboard? Y N
Have you ever been told you should stop driving? Y N

Is there a family history of:

Diabetes? Y N Heart? Y N

Macular degeneration? Y N Glaucoma? Y N

Any other eye conditions in the family? (Please list condition and how person is related to you)?_____

_____

_____

Please list any hobbies you would like help with:

_____

_____

_____

Name: _____

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Are you interested in free talking books? Y N

Are you interested in listening to the newspaper? Y N

Do you have a handicap parking tag? Y N

Are you interested in Directory Assistance Exemption? Y N

Do you use a computer? Y N

Do you use a cell phone? Y N

Do you use a tablet? Y N

Do you use Alexa, Google Home or Siri at home? Y N

Are you a veteran? Y N

How did you learn about our office? _____

_____