Mr / Mrs / Ms / Dr

Patient History Form

Today's Date ____ /____/_____

Patient Name: _____ Date of Birth ____/____/_____

Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: (____) _____ Other: (____) _____

Occupation: _____ Employer: _____ Last Eye Exam: _____

Eyes ever been dilated: □ Yes (~Year _____) □ No Signature for acknowledgement of HIPAA: _____

Email Address: _____ Referred by/Heard about us from: _____

Insurance Information

Name of **VISION** Plan: _____ Name of **MEDICAL** Plan: _____

Policy Holder's Name: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's Date of Birth: _____
Relationship to Insured: □ Self □ Spouse □ Dependent Relationship to Insured: □ Self □ Spouse □ Dependent
Policy Holder's ID or SS#: _____ Policy Holder's ID or SS#: _____

Medical Conditions/Review of Systems: Do YOU currently have or have YOU ever had (if so, when?) any diagnoses in the following areas?
CIRCLE all that apply:

CONSTITUTIONAL: other/add'l info
Developmental Disabilities, Cancer, Fatigue, _____
ENT (Ears, Nose, Throat):
Hearing loss, sinusitis, dry mouth, laryngitis, _____
NEUROLOGICAL:
MS, Epilepsy, CP, Tumor, Stroke/CVA, Migraine, Autism, _____
PSYCHIATRIC:
Depression, ADD/ADHD, Anxiety, Bipolar, _____
CARDIOVASCULAR:
Hypertension, Stroke, Heart Disease, Vascular Disease, CHF, _____
RESPIRATORY:
Cigarette smoker, Asthma, COPD, Sleep apnea, _____

GASTROINTESTINAL/GENITOURINARY: other/add'l info
Crohn's, Colitis, Ulcer, Acid Reflux, Celiac, _____
Kidney disease, Prostate, STD, currently Pregnant/Nursing _____
MUSCULOSKELETAL:
Osteoarthritis, Fibromyalgia, MD, AS, Osteoporosis, Gout, _____
INTEGUMENTARY (skin):
Eczema, Rosacea, Herpes zoster/shingles, Herpes Simplex/Cold Sores
ENDOCRINE:
Type 2 Diabetes, Type 1 Diabetes, Thyroid, Hormonal, _____
HEMOTOLOGIC/LYMPHATIC:
Anemia, Ulcer, High Cholesterol, Other _____
ALLERGIC/IMMUNE:
Environmental Allergies, Rheumatoid Arthritis, Lupus, Sjogren's, _____

***PRIMARY CARE DOCTOR:**
Name/Address/Clinic Name:_____

LIST ANY MEDICATIONS (AND DOSAGES) you take (include over-the-counter medicine, **eye drops**, vitamins and supplements):

_____

_____

_____

Do you have any allergies to medications: Y N If yes, list/explain_____

Ocular/Eye/Vision Review of Systems:

Do YOU currently have?			**Have YOU ever had?**		
Blurred Vision	Y	N	Eye Infection(s)	Y	N
Dry Eyes	Y	N	Glaucoma (or suspect)	Y	N
Itchy Eyes	Y	N	Cataracts	Y	N
Eye Discharge	Y	N	Macular Degeneration	Y	N
Tearing	Y	N	Retinal Detachment	Y	N
Floating Spots	Y	N	Lazy Eye	Y	N
Flashing Lights	Y	N	Eye Surgery	Y	N
			Dry Eye	Y	N

Details:_____

Contact Lens Questions:

Are you interested in contact lenses?	Y	N
Have you ever worn contacts?	Y	N
Do you now wear contacts?	Y	N
What type? _____		
How long have you had this pair? _____		
Do you sleep in your contacts?	Y	N
Are you happy with your current lenses?	Y	N
Feel dry/irritated with your current brand?	Y	N
Are you interested in trying a new lens?	Y	N
Are you interested in Laser Eye Surgery?	Y	N

Family History: Please note any **immediate family members (parents, siblings, children)** with any of these conditions:

Cancer	Y	N	Who: _____		Cataracts	Y	N	Who: _____
Diabetes	Y	N	Who: _____	Type 1 or 2	Macular Degeneration	Y	N	Who: _____
Hypertension	Y	N	Who: _____		Glaucoma	Y	N	Who: _____
Thyroid	Y	N	Who: _____	Hyper or Hypo	Blindness	Y	N	Who/Cause: _____