PATIENT HISTORY FORM

NAME: LAST: _____ FIRST: _____ PARENT/GUARDIAN: _____

DOB: _____ **AGE:** _____ **WILL YOU BE USING INSURANCE TODAY? YES NO**

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ HOME PHONE: _____ WORK PHONE: _____

EMAIL: _____ HOBBIES: _____

OCCUPATION: _____ IF PREGNANT, PLEASE STATE NUMBER OF MONTHS: _____

MEDICAL HISTORY

PLEASE LIST CURRENT MEDICATIONS: _____

_____

_____

PLEASE LIST ANY ALLERGIES (MEDICAL OR ENVIRONMENTAL)

_____

_____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU.
IN THE LAST COLUMN, CIRCLE S for SELF - and - F for FAMILY AND INDICATE HOW LONG YOU HAVE HAD THE CONDTION.

{ } AMBLYOPIA (LAZY EYE)	{ } FLOATERS	{ } CANCER:	S	F	_____
{ } BLURRED VISION - DISTANCE	{ } FLUCTUATING VISION	{ } DIABETES:	S	F	_____
{ } BLURRED VISION - NEAR	{ } FOREIGN BODY SENSATION	{ } GLAUCOMA:	S	F	_____
{ } CATARACTS: YEAR _____	{ } GLARE/LIGHT SENSITIVITY	{ } HEART DISEASE:	S	F	_____
{ } CHALAZION/STYES	{ } HEADACHES/MIGRANES	{ } HIGH BLOOD PRESSURE:	S	F	_____
{ } COLOR BLINDNESS	{ } LAZY EYE right or left	{ } HIGH CHOLESTEROL:	S	F	_____
{ } DOUBLE VISION	{ } LOSS OF VISION	{ } MACULAR DEGENERATION:	S	F	_____
{ } DRYNESS	{ } REDNESS	{ } THYROID DISEASE:	S	F	_____
{ } EXCESS TEARING/WATERING	{ } RETINAL DETACHMENT				
{ } FLASHES	( ) SURGERY (EYE) – Year _____				

PREVIOUS EXAM INFORMATION

HAVE YOU EVER HAD AN EYE EXAM BEFORE? YES NO → → IF YES, HAVE YOU BEEN TO OUR OFFICE BEFORE? YES NO

IF NOT, PLEASE TELL US WHERE YOU HAD YOUR LAST EXAM: _____ DATE OF LAST EXAM _____

REASON FOR YOUR VISIT TODAY (PLEASE CHECK ALL THAT APPLY)

{ } I NEED AN ANNUAL EYE EXAM FOR **GLASSES**
{ } I LOST/BROKE MY GLASSES
{ } I HAVE AN INFECTION/RED EYES
{ } I NEED AN ANNUAL EYE EXAM FOR **CONTACTS** (Includes glasses prescription)
{ } I WOULD LIKE TO GET MY EYES DILATED
{ } I WOULD LIKE TO DISCUSS WITH DOCTOR

ANSWER THE QUESTIONS IN THIS COLUMN BELOW:

HAVE YOU EVER WORN GLASSES BEFORE? YES NO

IF YOU HAVE, DO YOU CURRENTLY WEAR GLASSES? YES NO
IF YES, DID YOU BRING YOUR GLASSES TODAY? YES NO

HOW OLD ARE YOUR GLASSES? _____
TYPE: ( ) SINGLE VISION ( ) BIFOCAL ( ) TRIFOCAL
( ) PROGRESSIVE-(No line) ( ) READERS ( ) OTHER

DO USE THE COMPUTER? YES NO
HOW MANY HOURS PER DAY? _____

ANSWER THE QUESTIONS BELOW ONLY IF YOU ARE DOING CONTACT EXAM:

HAVE YOU EVER WORN CONTACTS BEFORE? YES NO

IF YOU HAVE, DO YOU CURRENTLY WEAR CONTACTS? YES NO
IF YES, HOW OFTEN DO YOU REPLACE THEM? _____
ARE YOU WEARING YOUR CONTACTS TODAY? YES NO
WHAT BRAND? _____
ARE YOU HAPPY WITH YOUR CURRENT BRAND? YES NO
DO YOUR REMEMBER YOUR PRESCRIPTION? YES NO
RIGHT _____
LEFT _____

ARE YOU INTERESTED IN COLOR CONTACTS? YES NO

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROVIDE THE MOST BENEFICIAL AND COMPLETE VISUAL EXAMINATION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALLL CHARGES WHETHER OR NOT PAID BY INSURANCE. I UNDERSTAND THAT ALL FEES PAID FOR PROFESSIONAL SERVICES ARE NON-REFUNDABLE AND ARE PAYABLE AT THE TIME OF SERVICE. MY SIGNATURE INDICATES THAT I HAVE BEEN INFORMED OF MY RIGHTS UNDER THE HIPPA PRIVACY POLICIES.

SIGNATURE: _____ DATE: _____