

PATIENT HISTORY

Date _____ Name _____ Date of Birth _____ Age _____ Home ph _____

Address _____ City/State/Zip _____ Cell/work ph _____

Email _____ Parent/guardian _____ Family Dr. _____ ph _____

Occupation _____ Hobbies/Sports/Visual Needs _____ Computer Usage _____ hrs/day

Who may we thank for referring you to us? _____ When/where was your last eye exam? _____

Reason for Visit Today _____

Currently wear: Glasses Contact lenses, if yes, brand _____ Are you interested in contact lenses? No Yes

Current Eye Symptoms:

- | | | | |
|--|--|--------------------------------------|---|
| <input type="checkbox"/> Distance vision blurred | <input type="checkbox"/> Double vision | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> None, routine exam |
| <input type="checkbox"/> Near vision blurred | <input type="checkbox"/> Red eyes | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Other/comments _____ |
| <input type="checkbox"/> Eyestrain | <input type="checkbox"/> Burning eyes | <input type="checkbox"/> Watery eyes | |

Eye History: (check those that apply to you)

- Glaucoma Cataracts Macular degeneration Eye injury Eye surgery Other _____

Personal Medical History: (check those that apply to you)

- | | | |
|---|---|---|
| <input type="checkbox"/> Skin disease | <input type="checkbox"/> Neurological (MS, migraines) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis/bone problem | <input type="checkbox"/> Breathing/lung problem | <input type="checkbox"/> Heart/cardiovascular disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood problem | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Psychiatric disorder | <input type="checkbox"/> Other _____ |

Family History: (check those that apply to your blood relatives)

- Diabetes Glaucoma Retinal detachment Macular degeneration Other eye disease _____

Please list any medications you are taking: _____

Are you allergic to any medications? No Yes: _____

Do you smoke? No Yes

Are you pregnant? No Yes

HIPAA NOTICE

I have seen (on the wall) or been offered a copy of the HIPAA Privacy Notice. Sign: _____

CONSENT TO BILL INSURANCE

I authorize this office to bill and collect payment for services rendered to me and to use a photocopy of my signature. I understand I am financially responsible for all non-covered services.

Sign: _____

EYE DILATION

The doctor may need to give you some mild eye drops to allow him/her to check for eye diseases and prescribe the most accurate prescription. The eye drops temporarily make you more light sensitive and make your near vision blurry. Distance vision is not usually affected. Sunglasses will be provided. **Please initial:**

_____ It is OK to dilate my eyes. _____ I do not want my eyes dilated. Sign: _____

FOR CONTACT LENS WEARERS

Contact lenses are medical devices available by prescription only. As with any drug or device, contact lens wear is not without risk. There is a small but significant risk of serious complications associated with contact lens wear. If you experience any pain, redness, discharge, loss of vision or light sensitivity, remove your contact lenses immediately and call our office or another eye specialist.

Sign: _____