Medical History

Today's Date: ____/____/_____

Patient Information:

Last Name: _____

First Name: _____ Middle: ____

Nick Name: _____

Date of Birth: ____/____/_____ SSN: _____

Male / Female Marital Status: S / M / D / W

Mailing Address: _____

City: _____ State: _____ Zip: _____

☐ *Mailing Address: same as Insured/Responsible Party*

Email: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Text ok: YES or NO

Preferred contact method: Cell/home phone/work phone/email

Employer: _____

Occupation: _____

Is the patient the insured? ☐ Yes ☐ No

Insured/Responsible Party Information:

Relationship to patient: _____

Last Name: _____

First Name: _____ Middle: ____

Nick Name: _____

Date of Birth: ____/____/_____ SSN: _____

Male / Female Marital Status: S / M / D / W

Mailing Address: _____

City: _____ State: _____ Zip: _____

☐ *Mailing Address: same as the Patient*

Email: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Text ok: YES or NO

Preferred contact method: Cell/home phone/work phone/email

Employer: _____

Occupation: _____

Vision Insurance

Vision Insurance: _____

Member ID # _____

Primary Holder: _____

Secondary Insurance: _____

Member ID # _____

Primary Holder: _____

Medical Insurance

*Please provide a copy of insurance cards.

Medical Insurance: _____

Member ID # _____

Primary Holder: _____

Secondary Insurance: _____

Member ID # _____

Primary Holder: _____

Previous Eye Doctor: _____

Name of the office: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone# _____ Fax # _____

Primary Medical Physician: _____

Name of Physician's office: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone# _____ Fax # _____

It is your responsibility to know your insurance policy & be familiar with your coverage. *Our relationship is with you – not your insurance company*. Any amount *approved* by insurance company, *but not paid*, will be your responsibility. All insurance cards must be presented at the time of service. If all of your insurance cards are not provided at the time of your initial service, then this office has no responsibility to submit insurance claims on your behalf. If insurance information is not provided by you at the initial visit, any insurance filing will be your responsibility.

- **Patient (or Guardian) Signature:** _____

What was approximate date of your last eye examination? _____

How did you learn about our office?

- ☐ Family/Friend: _____
- ☐ Drive by
- ☐ Internet
- ☐ Phone book
- ☐ Location
- ☐ Other: _____

What is the main reason for your visit today?

_____

_____

Do you currently wear glasses?

- ☐ No
- ☐ Full time
- ☐ Reading only
- ☐ Driving only

Do you wear contacts? Yes or No

- ☐ I would be interested in wearing contacts

move up

Have you had Lasik Surgery?

Yes or No **Date of Surgery:** _____

***Are you interested in Lasik Surgery?** Yes or No

add Do you use tobacco? Yes or No

Please list any surgeries you have had:

_____

_____

Do you have any allergies? None Known

Medication/Material	**What reaction did you have?**
_____	_____
_____	_____
_____	_____
_____	_____

Which medication do you currently take?

None Aspirin on a daily basis? Yes or No

Medication Name: _____

_____

_____

_____

_____

_____

Do you have any of these eye symptoms?

- ☐ Blurred distance
- ☐ Blurred Reading vision
- ☐ Double vision
- ☐ Glare, halos around lights
- ☐ Flashing lights
- ☐ Floaters
- ☐ Foreign Body Sensation
- ☐ Red eye
- ☐ Dry Eye
- ☐ Tearing
- ☐ Burning
- ☐ Itching
- ☐ Eye Pain

Do you have any of these eye problems?

- ☐ Cataract
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Serious eye injury
- ☐ Iritis/uveitis
- ☐ Lazy eye
- ☐ Retinal detachment
- ☐ Wore an eye patch as a child
- ☐ Other: _____

Have you ever had any of these conditions?

- ☐ Stroke
- ☐ Dizziness
- ☐ High blood pressure
- ☐ Arthritis
- ☐ Allergies
- ☐ Heart disease
- ☐ Diabetes
- ☐ AIDS
- ☐ HIV
- ☐ Lung diseases
- ☐ Cancer
- ☐ Anemia
- ☐ Thyroid Disease
- ☐ Headaches
- ☐ Other: _____

Have members of your family had any eye diseases?

(This would be your father, mother, siblings, grandparents)

- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular degeneration
- ☐ Retinal Detachment
- ☐ Diabetes
- ☐ Diabetic eye diseases
- ☐ Blindness
- ☐ Poor vision
- ☐ Crossed Eyes
- ☐ Iritiis/uveitis
- ☐ Other: _____