



Welcome to our office!

Name: _____ Gender: Male Today's date: _____

Female

Address: _____ Cell Phone: _____

City, St, Zip: _____ Home Phone: _____

E-mail Address: _____ Work Phone: _____

What is the best way to communicate with you? Home Phone Work Phone Cell Phone Email

Birth Date: _____ SS#: (optional) _____

MEDICAL HISTORY

Previous Eye Doctor: _____ Last eye exam: _____

Medical Doctor: _____ Last medical: _____

Emergency Contact: _____ Phone: _____

Parents (if minor): _____ Spouse: _____

How did you find out about our office? Physician: _____ Referred by: _____
 Insurance Location Phonebook Radio Internet Other: _____

Do you wear Glasses Soft Contact Lenses Hard Contact Lenses
Are your contact lenses comfortable: Yes No

Allergic to any prescription medications? No Yes (list) _____

List medications and supplements you are currently taking:	Dosage	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If more space is needed, please continue on the back of this page

Ocular History: _____ Injuries/Surgeries: _____

Currently pregnant or nursing? No Yes Delivery Date: _____

FAMILY HISTORY None Unknown/Adopted

Family Medical History: Note relation to yourself on the blank line (ex: mother, paternal grandmother, maternal grandfather, etc.)
Conditions/Relation

- Glaucoma _____
- Macular Degeneration _____
- Retinal Detachment _____
- Cataract _____
- Crossed Eyes _____
- Blindness _____
- Unknown _____
- Diabetes _____
- High Blood Pressure _____
- Thyroid Disease _____
- Heart Disease _____
- Cancer _____
- Other _____
- Unknown _____

LIFESTYLE HISTORY

(This information is kept confidential. You may discuss this portion directly with the doctor if you prefer)

Preferred Language: English Spanish Other: _____

Race: American Indian or Alaska Native Native Hawaiian or Other Pacific Islander Asian
 Black or African American White

Ethnicity: Hispanic Not Hispanic

Smoking Status: Current every day smoker Current some day smoker Former smoker
 Never smoker Smoker, current status unknown Unknown if ever smoked

Do you use tobacco products? No Yes If yes, type/amount/how long: _____

Do you drink alcohol? No Yes If yes, type/amount/how long: _____

Do you use recreational drugs? No Yes If yes, type/amount/how long: _____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas? None

Eyes

- Glaucoma
- Macular Degeneration
- Retinal Detachment
- Cataract
- Lazy Eye/Amblyopia
- Vision Loss
- Crossed Eyes/Strabismus
- Dryness
- Color Blindness
- Double Vision
- Chronic Eye Infection
- Floaters/Flashes
- Blurred Vision

Allergic/Immunologic

- Seasonal Allergies

Musculoskeletal

- Arthritis
- Ankylosing Spondylitis

Cardiovascular

- Hypertension
- High cholesterol
- Heart Disease

Constitutional

- Fever
- Fatigue

Ears, Nose, Mouth, Throat

- Chronic Cough
- Sinus Congestion
- Dry Throat/Mouth

Endocrine

- Diabetes
Year Diagnosed _____
- Thyroid Dysfunction

Gastrointestinal

- Irritable Bowel Syndrome
- Crohn's Disease

Genitourinary

- Kidney Problems
- Bladder Problems

Integumentary (skin)

- Rosacea
- Eczema

Lymphatic/Hematologic

- Anemia
- Bleeding Problems

Neurological

- Headaches
- Migraines
- Multiple Sclerosis
- Seizures

Psychiatric:

- ADHD
- Depression

Respiratory

- Asthma
- Emphysema
- Bronchitis

Please explain any items checked above and list any conditions not included above.

Doctor's Signature: _____ Date: _____

Notice of Privacy Practices

I acknowledge that I have been offered a copy of the Notice of Privacy Practices

Signature

Date

Financial Responsibility

- I authorize release of medical information regarding my treatment, to my insurance company, necessary for payment of services and materials provided by this office
- I authorize this office to accept assignment and receive payment directly from my insurance company, if billed
- If a patient balance remains for services or materials I may also be responsible for interest of 1.5% per month (18% per year)
- I understand there is a \$28 service fee for returned checks
- I agree to pay all court costs and attorney fees, including charges and commissions up to 40% that may be assessed to us by any collection agency retained for delinquent accounts.

Signature

Date

Release of Information (who do you want us to share any of your information with? Your spouse, child, etc.?)

I authorize release of my medical and billing information to

This release is valid for () 1 year () 3 years () until revoked

Relationship: _____

Signature

Date

I have reviewed and updated, as needed, my Medical History Questionnaire

- Visit 2 Patient signature: _____ Date: _____
- Visit 3 Patient signature: _____ Date: _____
- Visit 4 Patient signature: _____ Date: _____
- Visit 5 Patient signature: _____ Date: _____
- Visit 6 Patient signature: _____ Date: _____
- Visit 7 Patient signature: _____ Date: _____
- Visit 8 Patient signature: _____ Date: _____
- Visit 9 Patient signature: _____ Date: _____
- Visit 10 Patient signature: _____ Date: _____