Medical History

Name: Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Gender: M / F Date:\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_St: \_\_\_\_\_ Zip code:\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_ Phone: Hm/Cell (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wk(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ext\_\_\_\_\_\_

DRIVER’S License:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear of us:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Insurance Holder***

1° Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_/\_\_\_\_/\_\_\_\_\_ SSN:\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_

Relationship to Pt \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Member ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2° Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_/\_\_\_\_/\_\_\_\_\_ SSN:\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_

Relationship to Pt \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please circle if you or your family have/had the following conditions*

Occular Hx: Self Family Self Family General Hx: Self Family

Blurry Vision S F Glaucoma S F Diabetes S F

Eye Infection S F Macular degeneration S F High Blood Pressure S F

Light Sensitivity S F Retinal Problems S F Heart Disease S F

See Flashes/Floaters S F Strabismus (Eye Turn) S F Cancer/ Tumors S F

Eye Surgery S F Amblyopia (Lazy Eye) S F Thyroid Disease S F

Double Vision S F Cataracts S F Arthritis S F

|  |  |
| --- | --- |
| Special Needs  Which of the following applies to you? (Check)  \_\_\_Close fine detail work \_\_\_Read for extended periods  \_\_\_Play a musical instrument \_\_\_Use a computer | LASIK / Contact Lens Interest?  Had LASIK done before? Y N Are you interested in LASIK? Y N  Do you currently wear Contact lenses? Y N Sleep in them? Y N  If YES: \_\_\_Soft \_\_\_Hard \_\_\_Astigmatism \_\_\_\_Bifocal  How often do you dispose you lenses? Interested in COLOR contacts? Y N |
| Outdoors/ Sports  What sports / activities do you enjoy?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you currently wear sun protection? Y N  Do you currently wear Safety goggles Y N |
| Lighting Comfort  Do you suffer from tearing, itchy, burning, gritty watery eyes? Y N  What light conditions causes you the most problem? (Check)  \_\_\_Night time glare/reflections \_\_\_Sunlight \_\_\_Artificial (Flourescent) |

I, the undersigned, certify that my dependent or I have insurance with the company listed above and assign all benefits directly to the doctor. I understand that I am financially responsible for all charges. I hereby authorize the office to release all information necessary to secure payment of benefits. By signing below I authorize all insurance submission.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_