Patient History Form Date ___/___/___

Name_____DOB ____/____/____ SSN _____- _____ - _____

Address_____Zipcode_____

Cell Phone _____ Work Phone _____ Occupation _____

Medial Insurance_____Insured Party _____Policy # _____

Do you now, or have you ever had	Y	N
Diabetes?	☐	☐
Do you use insulin?	☐	☐
High blood pressure?	☐	☐
Heart attack?	☐	☐
Arthritis?	☐	☐
Cancer?	☐	☐
Migraine headache?	☐	☐
Lung Disease/ Asthma?	☐	☐
HIV / AIDS?	☐	☐
TB?	☐	☐
Syphilis?	☐	☐
Sarcoid?	☐	☐
Sickle cell disease / trait?	☐	☐
Multiple Sclerosis?	☐	☐
Crohn's disease?	☐	☐

Do you have allergies to medication? Please list.

_____

_____

Please list any previous surgeries.

_____

_____

Do you have any medical problems not mentioned?

_____

Do you smoke?	☐	☐
# of cigarettes per day. _____		
Do you drink alcohol?	☐	☐
# of drinks per week. _____		

Please continue on the other side.

Does anyone in your family had …	Y	N
Diabetes	☐	☐
Heart disease / hyperstension?	☐	☐
Glaucoma?	☐	☐
Macular degeneration?	☐	☐
Other eye disease? _____		

Are you currently experiencing.....		
Weight loss?	☐	☐
Weight gain?	☐	☐
Fatique?	☐	☐
Fever?	☐	☐
Chest pain?	☐	☐
Swelling of the feet?	☐	☐
Excessive thirst?	☐	☐
Shortness of breath?	☐	☐
Cough?	☐	☐
Wheezing?	☐	☐
Easily broken bones?	☐	☐
Headaches?	☐	☐
Abdominal pain?	☐	☐
Swollen lymph nodes?	☐	☐
Seizures?	☐	☐
Weakness of extremities?	☐	☐
Numbness of extremities?	☐	☐
Decrease in hearing?	☐	☐
Hearing aid use?	☐	☐
Runny nose?	☐	☐
Sinus problems?	☐	☐
Sore throat?	☐	☐
Easy bruising?	☐	☐
Skin rash?	☐	☐
Skin lesions?	☐	☐
Heartburn?	☐	☐
Depression or nervousness?	☐	☐

Are you experiencing....	Y	N		Y	N
Blurred vision?	☐	☐	When you were a child did you wear a patch?	☐	☐
Blurred computer vision?	☐	☐	Do you see flashes of light?	☐	☐
Do your eyes water?	☐	☐	Do you see floaters?	☐	☐
Do your eyes itch?	☐	☐	Have you ever had trauma to your eye?	☐	☐
Do your eyes burn?	☐	☐	Do you use eyedrops?	☐	☐

Contact Lenses

	Y	N	
Do you currently wear contact lenses?	☐	☐	What brand?_____
If not, have you ever worn them?	☐	☐	
Do you rub your lenses to clean them?	☐	☐	
Do you wear your contacts everyday?	☐	☐	
Are you interested in being fit/refit today?	☐	☐	
Are you having problems with your lenses?	☐	☐	

What are they? _____

What solutions do you use? _____ Generic _____

When was your last eye exam? _____ Dr._____

When was your last medical examination? _____Dr._____

Doctor's phone _____

Please list the medications you are presently taking?

_____

_____

_____

_____

Our office policy: **Please read carefully.**

1. Fees for service are due at the time of service. This includes co-pays and deductibles. There are additional fees for contact lens related services.
2. Insurance agreements are between you and your insurance company. We will gladly assist you with our experience and expertise in obtaining payment from your insurance company. Ultimately, you are responsible for the services rendered to you.
3. Any materials ordered (glasses or contact lenses) require a 50% deposit, exclusive of possible insurance payments. This is NON REFUNDABLE once the materials are ordered. Neither will a credit be issued.
4. There are no refunds or credits for materials left in our office for 60 days. There are NO EXCEPTIONS.

I understand the above office policies. I authorize the release of any medical information to my insurance companies. A copy of this form may be used as authorization. I further understand that if my account is sent to collection for any reason, I am responsible for all legal fees, collection fees, and interest on my account.

Signed _____ Date _____