

WELCOME TO EYEDESIGNS OPTOMETRY

Thank you for choosing our office for your eye care needs. Please fill out this entire patient medical history form and sign the bottom.

Name: _____ Title: Mr. Ms. Mrs. Dr. Today's Date: _____
Last First MI

Nickname / AKA _____ Male Female Date of Birth: _____ Social Security #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____ E-Mail: _____

Preferred Method of Notification: Text Message Email Cell Phone Home Phone Post Card

Occupation / Grade Level: _____ Employed by / School: _____

Marital Status: Single Married Domestic Partner Separated Divorced Widowed Minor

In case of emergency, contact: _____ Relationship: _____ Phone: _____

Vision Insurance: VSP (Vision Service Plan) Medicare None Other: _____

Primary Care Physician: _____ Phone or City: _____ Last Exam Date: _____

Health Insurance: _____ Member ID/Medicare #: _____

How did you hear about our office? Insurance List Internet Yelp Referred By: _____

PERSONAL & FAMILY EYE / MEDICAL HISTORY

Date of Last Eye Exam: _____ Purpose for today's visit: _____

Do you wear glasses? No Yes Age of your present glasses? _____ Do you wear Contact Lenses? No Yes Interested

Do you use a computer? No Yes, Hours per day? _____ Please list important Visual Chores/Hobbies/Sports: _____

Do you have any allergies (medicines, food, pollen, animals)? No Yes, Please List: _____

List your medications (include non-prescription, birth control, homeopathic & vitamins): _____

List any major injuries or surgeries: _____

Do you currently, or have you had any health conditions in the following systems? Please check all that apply:

<u>Constitutional</u> <input type="checkbox"/> Fever/Wt.Gain or loss	<u>Respiratory</u> <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Emphysema	<u>Genitourinary</u> <input type="checkbox"/> kidney/bladder	<u>Bones/Joints/Muscles</u> <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Joint or Muscle Pain	<u>Lymphatic/Hematologic</u> <input type="checkbox"/> Anemia/bleeding
<u>Integumentary</u> <input type="checkbox"/> Skin	<u>Endocrine</u> <input type="checkbox"/> Thyroid <input type="checkbox"/> Diabetes	<u>Ears, Nose, Mouth, Throat</u> <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> Dry Throat/Mouth	<u>Vascular/Cardiovascular</u> <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Vascular Disease	<u>Psychiatric</u> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Other _____
<u>Neurological</u> <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Seizures <input type="checkbox"/> Tumor	<u>Gastrointestinal</u> <input type="checkbox"/> Diarrhea	<u>Allergic/Immunologic</u> <input type="checkbox"/> Allergy/Hay fever <input type="checkbox"/> AIDS/HIV/Hepatitis		<u>Other</u> <input type="checkbox"/> Pregnant

If you answered yes to any of the above, please explain: _____

Do you or any of your blood relatives have any of the following conditions that affect vision? Please check and state relationship to you

<input type="checkbox"/> Blindness _____	<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> Retinal Disease/Detachment _____
<input type="checkbox"/> Cataracts _____	<input type="checkbox"/> Macular Degeneration _____	<input type="checkbox"/> Crossed or Lazy Eye _____
<input type="checkbox"/> Eye Injury/Infection _____	<input type="checkbox"/> Eye Surgery _____	<input type="checkbox"/> Cancer/Type _____
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Other: _____

SOCIAL HISTORY

This information is strictly confidential. Please fill out as completely as possible. However, if you wish to discuss these questions directly with the doctor, leave the questions unanswered and check this box: I would prefer to discuss my Social History information directly with the doctor.

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 illegal/social drugs? No Yes If yes, type/amount/how long?: _____

Have you ever been exposed to infectious disease? No Yes If yes, please indicate (HIV, Hepatitis, Syphilis, etc.): _____

AUTHORIZATION

I, the undersigned, declare, to the best of my knowledge, the above to be true. I understand that I am financially responsible for all services provided by the doctors and staff of EyeDesigns Optometry to me (or my dependent), whether or not paid for by insurance. I hereby authorize the release of any medical information necessary and the use of my signature to process my insurance claims; and I authorize payment of insurance benefits to include basic and major medical benefits to either myself or the party who accepts assignment with my insurance company.

Date: _____ Signature of patient or responsible party: _____