Confidential Medical History Form

Name_____Preferred Name_____ Date of Birth_____
Address_____ City_____ State_____ Zip Code_____
Home Phone_____ Cell Phone_____ Social Security#_____
Work Phone_____Occupation_____ Employer_____
Physician_____ Health Insurance Plan_____ Vision Insurance_____
Spouse_____ Email Address:_____
Insurance Responsible Party_____Date of Birth_____Last 4 of SS#_____
Referred By:_____ Hobbies:_____

Personal Health and Ocular History

List all medications you are taking (including oral contraceptives, over the counter medications including vitamins)

_____ _____
_____ _____
_____ _____

List all Allergies_____
List all major injuries or surgeries and/ or hospitalizations you have had:

_____
_____

Have you had any of the following: Please Circle

Crossed Eye
Lazy Eye
Glaucoma
Retinal Disease
Macular Degeneration
Cataracts
Drooping Eyelids
Eye Infections
Eye Injury
Other_____

Have you had Lasik Vision Surgery? Yes No
If yes, When? _____
Are you interested in laser vision correction? Yes No
Do you wear glasses? Yes No
How old are your glasses? _____
Do you wear contacts? Yes No
What type of contacts?_____
How old are your present contacts?_____
Are they comfortable? Yes No
(Non- Current Wearers) Are you interested in trying contacts? Yes No
Do you drink alcohol? Yes No
Do you use illegal drugs? Yes No
Do you use tobacco products? Yes No
How Long_____ How Much_____
Have you ever been exposed to or infected with STD'S? Yes No If Yes, please specify_____

I certify that the information I have given in reference to my medical insurance and secondary insurance is correct. I authorize use of forms on all my insurance submissions. I authorize release of information to all my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment direct to my doctor. I permit a copy of this authorization to be used in place of the original. **In the event my private insurance/secondary insurance company fails to pay for services, or the balance is applied to my deductible. I understand that I am fully responsible for payment of the balance to the doctor.**

_____ _____ Date _____
Print Patient Name Signature of Patient/Legal Guardian

Do you currently or have had any chronic problems with any of the following (Please Circle)

Sudden Weight Gain/Loss
Skin Problems

Neurological
Headaches
Migraines
Seizures

Eyes
Loss of Vision
Dryness
Mucous Discharge
Redness
Sandy Gritty Feeling
Itching Eyes
Burning Eyes
Foreign Body Sensations
Excess Tearing/ Watering
Glare/Light Sensitivity
Eye Pain/Soreness
Chronic Infection eye/lid
Flashes/ Floaters
Tired Eyes

Endocrine
Thyroid Disorder
Allergy/Immunological

Psychiatric
Depression
Anxiety Disorder
Alzheimer's Disease

Ear, Nose, Throat, Mouth
Allergies, Hay Fever
Sinus Congestion
Runny Nose
Post- Nasal Drip
Chronic Cough
Dry throat, Mouth

Respiratory
Asthma
Chronic Bronchitis
Emphysema

Cardiovascular
Diabetes
Heart Pain
High Blood Pressure
Vascular Disease

Genitourinary
Menopause
Genitals
Kidney
Bladder

Bones/Joints/Muscles
Rheumatoid Arthritis
Muscle Pain
Joint Pain

Lymphatic/Hematological
Anemia
Bleeding Problems

Please List any other conditions that are not listed above:_____
_____

Have any of your parents, grandparents, siblings, or any other relative have had the following:

	Please Circle		Relationship to you		Please Circle		Relationship to you
Blindness	Yes	No	_____	High Blood Pressure	Yes	No	_____
Crossed Eye	Yes	No	_____	Lupus	Yes	No	_____
Macular Degeneration	Yes	No	_____	Thyroid Disease	Yes	No	_____
Retinal Detachment	Yes	No	_____	Cancer	Yes	No	_____
Cataract	Yes	No	_____	Heart Disease	Yes	No	_____
Glaucoma	Yes	No	_____	Kidney Disease	Yes	No	_____
Diabetes	Yes	No	_____	Other_____	Yes	No	_____

I acknowledge that I have received, read and understand a copy of the Notice of Privacy Practices and am aware that this notice is available to me upon request.

_____ _____ Date _____

Print Patient Name Signature of Patient/Legal Guardian