

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:

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

Have you ever been exposed to or infected with STD'S? Yes No If Yes, please specify _____

(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 _____

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.**

Print Patient Name

Signature of Patient/Legal Guardian Date _____

Do you currently or have had any chronic problems with any of the following

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.

Print Patient Name

Signature of Patient/Legal Guardian

Date