Patient Health Information and Medical History Form

Please Present Insurance Cards and Photo ID to Receptionist

Name_____Sex___ Birth Date_____
Address_____Social Security Number_____
City_____ST_____Zip_____
Phone(Home)_____(Work)_____(Cell)_____(Texting OK: Yes or No)
Employer_____ Email_____
Date of Last Eye Exam_____Name of Doctor_____ Medical Doctor_____

Check the conditions that you have or have had in the past.

[ ]Cataracts
[ ]Glaucoma
[ ]Eye Turn In or Out
[ ]Eye Disease
[ ]Eye Injury
[ ]Dry Eyes
[ ]Burning, Itching, Redness
[ ]Tearing
[ ]Light Sensitivity
[ ]Double Vision
[ ]Tired Eyes
[ ]Decreased Vision
[ ]Complete Loss of Vision
[ ]Headaches
[ ]Flashes [ ]Floaters

[ ]Heart Disease
[ ]High blood Pressure
[ ]Breathing/Lung Problems
[ ]Cancer
[ ]Diabetes
[ ]Bleeding Problems
[ ]Hepatitis, HIV, TB
[ ]Neurological Disease
[ ]Arthritis/Joint Disorder
[ ]Thyroid Disease
[ ]Dizziness
[ ]Skin Problems
[ ]Ulcer/Stomach Problems
[ ]Ear, Nose, Throat

Do any blood relatives have or have had?
[ ]Glaucoma
[ ]Eye Disease
[ ]Diabetes
[ ]High Blood Pressure
[ ]Heart Disease

Have you had eye surgery?____If yes, please describe_____
_____
List allergies to medications_____
List other allergies_____
Do you take medication regularly?____Please list all medicines(including eye drops) and dosages._____

Social history questions. (We are required to ask them.)
Do you: Exercise Y or N Use alcohol Y or N or tobacco Y or N

_____

By signing this form, I consent to treatment for myself and/or on behalf of the Minor for which this information pertains. I give permission for the doctor(s) to examine, diagnose and initiate treatment. I further attest that I am the Parent or Legal Guardian of the Minor and have the authority to authorize care and treatment. I am financially responsible for services and materials rendered. If enrolled in a health plan, I am responsible for all co-pays and non-covered services and materials.

_____
Patient (Parent or Guardian-Please sign and print name) Today's Date

_____
Doctor's Signature Tech Initials Review Date

Please complete Insurance Information form on the other side.