

PATIENT HISTORY

Last name _____ First Name _____ MI _____
 Address _____ City _____ State _____ Zip _____
 Telephone (H) _____ (W) _____ (C) _____
 SSN _____ Date of Birth _____
 Patient occupation and employer _____
 Primary Vision Insurance _____ Primary Health Insurance _____
 Insured member name and relationship to patient (if not patient) _____
 Insured member SSN and DOB (if not patient) _____
 Member Employer _____

Date of last eye exam _____ Were your eyes dilated? _____
 What is the main reason for your visit today? _____

Do you have problems with any of the following body systems (circle all that apply)?

Allergic/immunologic	Y/N	Nervous	Y/N	Mental	Y/N
Gastrointestinal	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Ear/Nose/Throat	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N
Cardiovascular	Y/N	Integumentary (skin)	Y/N	Eyes	Y/N
Respiratory	Y/N				

If yes, please explain: _____
 Please answer the following:
 Are you diabetic? Y/N Type I or II _____ Is your sugar stable? Y/N _____ Date of diagnosis? _____
 Do you have High Blood Pressure? Y/N Is it stable? Y/N _____ Date of diagnosis? _____
 Do you have allergies? Y/N Do you have any allergies to medications? Y/N _____
 What are you allergic to? _____

Do you experience headaches? Y/N Describe briefly: _____
 Do you have any other health problems? Y/N Describe briefly: _____
 Are you taking any medications for any reason? Y/N Please list: _____
 Have you had any operations? Y/N Type and date of surgery: _____
 Do you use cigarettes or tobacco? Y/N Alcohol? Y/N Other substances? Y/N _____
 Name of family doctor: _____ Date of last visit: _____
 Approximate date of last Tetanus shot? _____
 Have you had an eye injury? Y/N Type? _____ Date _____
 Have you had any eye operations? Y/N Type? _____ Date _____
 Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N
 Any other eye problems? Y/N Please explain: _____
 Do you wear glasses? Y/N Contact Lenses? Y/N Type? _____
 Do you work on a computer? Y/N How often? _____ How long? _____
 Any additional information: _____

Family History:
 High Blood Pressure Y/N Relation _____ Diabetes Y/N Relation _____
 Cataracts Y/N Relation _____ Macular degeneration Y/N Relation _____
 Glaucoma Y/N Relation _____ Other eye conditions Y/N Describe _____

Patient authorization statement:
 I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to this provider for services rendered. Payment of non-covered expenses is due at time of service.

Signature _____ Today's date _____