Patient History

Last Name_____First Name
MI
Address_____ City_____ ST
Zip
Phone (H)_____ (W)_____ (C)
SSN/ID#_____ D.O.B
Occupation/Employer
Primary Vision Insurance
Primary Medical
Insurance_____
Insured Member/Relationship (if other than patient)_____
Insured Member's Employer (if other than
patient)_____
Insured Member's SSN/ID# (if other than
patient)_____
Insured Member's D.O.B. (if other than
patient)_____
Last Eye Exam_____ Were you Dilated?
_____
What is the main reason for your visit today?
_____
_____
__

Do you have problems with any of these systems (circle all that apply):

Allergic/Immunologic Y/N	Nervous Y/N	Mental Health Y/N
Ear/Nose/Throat Y/N	Endocrine Y/N	Genitourinary Y/N
Cardiovascular Y/N	Respiratory Y/N	Gastrointestinal Y/N
Musculoskeletal Y/N	Blood/lymph Y/N	Integument(skin) Y/N

if yes, please
explain:_____

Please answer all that apply:
Diabetic: Y/N Type: 1 or 2 Stable: Y/N Date of Diagnosis:_____
High Blood Pressure: Y/N Stable: Y/N Date of Diagnosis:_____
Allergies: Y/N Allergic to what:_____
Reaction:_____
Medication Allergy: Y/N Allergic to what:_____
Reaction:_____
Headaches: Y/N Describe
briefly:_____
Any other health
problems:_____
Current
Medications:_____
Have you had any operations? When:_____
Type:_____
Do you use: Cigarettes: Y/N Alcohol: Y/N Other Substances: Y/N
Name of Family Doctor:_____ Date of last
visit:_____
Date of Last Tetanus shot:_____

Family History:
High blood pressure: Y/N Relation_____ Diabetes: Y/N
Relation_____
Glaucoma: Y/N Relation_____ Cataracts: Y/N
Relation_____
Macular Degeneration: Y/N
Relation_____
Other Eye Conditions: Y/N what kind?_____
Relation_____

Have you had any eye operations or injuries: Y/N
Type:_____
Do you have: Glaucoma: Y/N Cataracts: Y/N Dry Eyes: Y/N Blurred vision: Y/N
other eye problems (please
explain):_____
Do you wear glasses: Y/N Type:_____ Contacts: Y/N
Type:_____
Do you work at a computer: Y/N How often:_____ How
long:_____
Additional
information:_____

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 the services rendered. Payment of non-covered expenses is due at the time of service.
Signature:_____ Today's
Date:_____
E-
Mail:_____
__
Who can we thank for referring
you?:_____