Medical History Form

Date:___/_____/_____ Name of Insurance: _____

First Name:_____ Initial:_____ Last Name:_____

If Child (Guardian Name):_____ Date of Birth:_____/_____/_____ Age:_____

Social Security: __ __ __ -__ __ -__ __ __ __ E-mail:_____

Address:_____ City:_____ State:_____

Zip code:_____ Telephone:_____ Cell phone:_____

Work :_____ Ext.:_____ Occupation:_____

Sex:_____ M _____F Marital Status : **S/M/W/D**

Patient History Information:

Chief Complaint: _____

A medical complaint includes blurry vision, watery, itchy eyes, flashes, floaters, vision loss, pain, light sensitivity, pressure.

During your visit today please circle if you would like a prescription for: Glasses /Contact lenses

Have you worn glasses? Y/N If so, how old are your current glasses? _____Yrs
Have you worn contact lenses? Y/N If so, how old are your contacts?_____ Type of contacts?_____

	YES	NO		YES	NO
Do you have high blood pressure?			High cholesterol?		
A history of stroke?			Asthma or lung problems?		
Diabetes?			Arthritis?		
HIV or AIDS?			A history of eye surgery?		
Macular degeneration?			Have you ever had retinal detachment?		
Gritty or sandy feeling in the eyes?			Thyroid condition?		
Floaters?			Do you have glaucoma?		
Do you have amblyopia (lazy eye)?			Cataracts?		
Poor vision, eye pain, tearing, redness etc.			Are you pregnant? Nursing?		
A history of ocular trauma?			Watery/Burning eyes?		

Medications:

Please list any medications you are taking and what they are for: _____
_____

Please list any allergies to medications you are aware of:_____
_____

List of surgeries you have had: _____
_____

Who is your medical doctor?_____ Phone #: _____
Date of last exam:_____

Who was your last optometrist?_____ Date of last eye exam: _____

Lifestyle:

What one word would you use to describe how your eyes feel at the end of the day? _____

Is there a specific activity you feel is limited by your vision? _____

If there is one thing about your current glasses you would change what would it be? _____

What percentage of your day do you spend outside? _____

Any special hobbies or interests we should know about? (i.e. piano, boating, shooting) _____

_____

How many hours do you spend in front of an electronic device (pc, tablet, Smartphone, Xbox)_____

***IMPORTANT**

The Florida Board of Optometry has established that a comprehensive eye examination for a new patient includes a Dilated Exam. This procedure involves putting one or more drops in each eye that will dilate the pupils. The doctor will then study the internal structures of the eye to ensure proper health. The drops will cause the eyes to be light sensitive and vision will be blurred, especially when reading near, for 4-6 hours. Some patients the effects will be longer. Driving may be difficult and should be done with extreme caution.

_____ Agree to have my eyes dilated. _____ Do not agree to have my eyes dilated.

HIPAA PRIVACY (Acknowledgement of Receipt of Privacy Notice)

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below. I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with my regarding vision care services provided by the Location (for example, mailings of exam reminders or information about services / products provided by the Location). I can be assured that this Location does not sell my personal health of any kind to a third party for such party's own use. I authorize the Location to submit my vision benefit claim to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from the Location.

Patient Signature or Patient's Legal Representative: _____ Date: _____

Physician's Signature:_____ Date:_____