MEDICAL HISTORY

***Patient's Name (First, Middle Init., Last)	Telephone Work: Home / Cell:	Patient Status Single, Married
Patient's Address: Zip Code: City, State:	Patient's DOB: (MM,DD,YYYY) Patient's SS#: - - Many insurances incorrectly require this. It's at your discretion but you agree to pay for the exam in it's entirely if your insurance will not cover the service (which is usually due to lack of SS#).	EMAIL:

I authorize the release of any information necessary to process my insurance claim or ***treat any medical/visual conditions***. I also request payment directly to my doctor. I realize that should this account be past due, I am responsible for all collection costs and legal fees. I also realize that if my insurance has not paid within 90 days that I am responsible for the balance in full. Also by signing the below I acknowledge that I have been offered the HIPAA NOTICE OF PRIVACY PRACTICES & CONTACT LENS DISCLOSURE.

***SIGNATURE (responsible party for patient above):_____DATE:_____/_____/_____

***Contact lenses: ANYONE can wear Contacts with ANY prescription, even ASTIGMATISM or bifocals. Interested? YES / NO
: If you wear contacts what type (Acuvue, Air Optix, etc) and power?_____

Who is the PATIENT'S family doctor?:_____

MEDICAL HISTORY

- ***** What is the patient ALLERGIC to:** 1._____ 2. _____ 3_____

- **ILLNESS** (Does the PATIENT have any problems in the following areas? **Circle Yes / No)**

Diabetes	Y / N	Glaucoma	Y / N	Asthma, breathing	Y / N	Thyroid	Y / N
High Blood Pressure	Y / N	Macular Degeneration	Y / N	Kidney, Liver	Y / N	Migraines	Y / N
Cholesterol, triglycer.	Y / N	Rheumatoid	Y / N	Anemia, sickle cell	Y / N	Other? Please list below:	

Other? (ie STD, cancer, surgery, etc):_____

- ***** List ALL MEDICATIONS (pills, eye drops, etc.) the PATIENT takes *****

1._____ 3._____ 5._____ 7._____

2._____ 4._____ 6._____ 8._____

Or provide us with your list given to you by your family doctor.

- Has Patient had surgery (especially to eyes/head/neck)? Why?_____
- Smoke/tobacco (amount per day)? Y / N_____ Do you drink alcohol (amount per day)? Y / N_____
- Severe Psychiatric problems(suicidal)? Y / N_____ Do you use street / illegal drugs? Y / N

- **FAMILY MEDICAL HISTORY** (M = mother, F = father, Br = brother, S = sister, GM = grandmother, GF = grandfather)
After circling Yes / No below; put M, F, Br, etc next to it indicating who has the disease. Ie Glaucoma Y M,Br,MGF

Bleeding Disorder Y / N ___	Glaucoma Y / N ___	High Blood Pressure Y / N ___	
Diabetes Y / N ___	Heart Disease Y / N ___	Macular Degeneration Y / N ___	Other? Please list below:

Other?:_____

- **REVIEW OF SYSTEMS:** (Circle any symptom or problem area **PATIENT *CURRENTLY*** has; write additional info if needed)

- Constitutional Symptoms
  - Severe Fatigue
  - Night Sweating
- Ears, Nose, Mouth, Throat
  - Ears
  - Nose
  - Mouth / Throat
- Respiratory (Lungs)
  - Severe shortness of breath
  - Smoker
- GI (Gastrointestinal: stomach, intestines, etc.)
  - Frequent diarrhea
  - Frequent vomiting
- GU (Genitourinary: Genitals & Urinary)
  - Urinate more than 2x/night (polyuria)
  - Kidney problems
- Integumentory (Skin)
  - Lesions
  - Severe dryness
- Psychiatric
  - Anxiety
  - Depression
  - Suicidal thoughts
- Endocrine
  - Sharp increase in thirst (polydipsia)
  - Liver problems
- Musculoskeletal (Muscles, Bones, Joints)
  - Severe joint pain
  - Severe muscle pain
- Neuro
  - Fainting (syncope)
  - Seizures
- Eyes
  - dryness
  - itching
- Cardiovascular
  - Heart trouble
  - Swelling of feet,ankles,hands
- Hematologic/Lymphatic
  - Anemia
  - Swollen glands
- Allergic/Immunologic
  - Frequent infections
  - hayfever