Patient Health History

Demographic/Contact Information

Patient Name: ____**Date of Birth:** ___________________________

Preferred Name*: ____**Gender:** ________________________________

Gender Identity* (If different from above): ____

Mailing Address: ____

Primary Phone: __________________**Secondary Phone:** ________________**Email:** ___________________________

Emergency Contact Name: ____**Phone:** __________________________

Occupation: ____**Employer:** _____________________________

Race/Ethnicity (Circle One): American Indian or Alaska Native • Asian • Black or African American

Native Hawaiian or Other Pacific Islander • White: Not Hispanic or Latino • White: Hispanic or Latino

Primary Language: English • French • Spanish • Other (Please specify)______________________________

*EyeCare of Vermont is committed to maintaining a positive, caring, and respectful environment for its patients and staff. We will do our best to use your preferred name and/or pronouns during your time in the office. For filing and billing purposes we are required to use the name that appears on your insurance card.

Medical History

Primary Care Physician: ______________________________________**Date of Last Exam:** ______________________

List any other doctors involved in your eye care: ____

____

List any current medications including over-the-counter, vitamins, and herbal therapy: ____________________

____

____

List all major surgeries, including eye surgery: ____

____

List any allergies to medications or eye drops: ____

____

Please list any accommodations you may require while visiting our office (Wheelchair accessible exam rooms, language interpreters, etc.): ____

Please indicate if any of the following currently apply to you

Wearing Full-Time Glasses	Yes / No	If Yes:	Circle One: Distance / Multifocal / Readers
Wearing Full-Time Contacts	Yes / No	If Yes:	Circle One: Distance / Multifocal
Taking Rx Plaquenil	Yes / No	If Yes:	Timeline/History: ______________________________
Taking Rx Tamoxifen	Yes / No	If Yes:	Timeline/History: ______________________________
Pregnant or Nursing	Yes / No	If Yes:	Timeline/History: ______________________________

Please indicate if you or a blood relative have a history of the following conditions

Condition	Self	Family	Relationship (if family member)
Retinal Detachment			
Blindness			
Cataracts			
Eye Turn			
Glaucoma			
Macular Degeneration			
Diabetic/ Pre-Diabetic (Circle: Type 1 or 2)			

Please check any current or past conditions that apply to you

	Hematologic		**Ear, Nose, & Throat**		**Allergies**		**Cancer/Oncology**
	Anemia		Sinusitis		Environmental/Seasonal		Type________________
	Leukemia		U. Respiratory Infection		Latex		Current / In Remission
	Bleeding Disorder		Hearing Loss		Other________________		**Endocrine/Glands**
	Other________________		Other________________		**Cardiovascular**		Hormone Dysfunction
	Immunologic		**Gastrointestinal**		High Blood Pressure		Thyroid Dysfunction
	Lupus		Crohn's Disease		Heart Disease		Other________________
	Rheumatoid Arthritis		Colitis		Stroke		**General Health**
	HIV Positive		Acid Reflux/Ulcers		Vascular Disease		Height_____'______"
	Hepatitis		Other________________		High Cholesterol		Weight________________
	Other________________		**Psychiatric**		Other________________		Recent Weight Change?
	Neurological		Depression		**Muscular/Skeletal**		Tobacco: Current User
	Multiple Sclerosis		Bipolar Disorder		Arthritis		Tobacco: Former User
	Epilepsy		Schizophrenia		Fibromyalgia		Alcohol Consumption
	Tremors		Other________________		Ankylosing Spondylitis		Drinks/Week__________
	Migraines		**Skin**		Other________________		Recreational Drugs
	Memory Loss		Eczema		**Respiratory**		Other________________
	Traumatic Brain Injury		Rosacea		Asthma		**Genital/Urinary**
	Developmental Diversity		Psoriasis		Bronchitis		Urinary Tract Infections
	Other________________		Shingles		Emphysema		Herpes/Chlamydia
			Other________________		Other________________		Other________________

Please sign below to acknowledge that you have completed this form to the best of your knowledge, and that you have received a copy of Eyecare of Vermont's HIPAA Notice of Privacy Practices.

Signature: ____**Date:** ___________________