Medical History

Name _____ Date _____/_____/_____

Address _____ Phone _____ Cell or Home?

City, State, Zip _____ Email_____

Birth Date _____/_____/_____ SSN# _____ Preferred Communication: Cell Email Home

Insurance: Vision ☐ None Ins. Carrier _____ Medical: ☐ None Ins. carrier _____

IF you are a new to our practice, who/how did you hear about us?_____

How do you protect your eyes from harmful UV sunlight?_____

Eye History: Do YOU have any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
Blurred Vision	☐	☐	Itching	☐	☐	Headache	☐	☐	Cataract	☐	☐
Flashes/Floaters	☐	☐	Redness	☐	☐	Tearing	☐	☐	Diabetes	☐	☐
Light Sensitivity	☐	☐	Dry Eye	☐	☐	Night Glare	☐	☐	Glaucoma	☐	☐
Double Vision	☐	☐	Burning	☐	☐	Eyestrain	☐	☐	Macular Degen	☐	☐

Review of Systems:

Do you currently have any of the following problems?	**Yes**	**No**	**If YES, please explain:**
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat Problems	☐	☐	_____
Neurologic Problems (MS, seizures, headaches, Parkinson's)	☐	☐	_____
Psychiatric Problems (depression, anxiety, ADHD)	☐	☐	_____
Cardiovascular (**High blood pressure**, heart attack, stroke)	☐	☐	_____
Respiratory (Asthma, Bronchitis, Lung disease, **Sleep Apnea**)	☐	☐	_____
Gastrointestinal (Heartburn, ulcers, liver/hepatitis, diarrhea)	☐	☐	_____
Genitourinary (Kidney, bladder, or prostate disease)	☐	☐	_____
Musculoskeletal (Rheumatoid Arthritis, muscle pain, joint pain)	☐	☐	_____
Skin/Integumentary (Acne rosacea, rashes, excessive dryness)	☐	☐	_____
Endocrine Problems (**Diabetes**, thyroid disease)	☐	☐	_____
Blood/Lymph (**high cholesterol**, anemia)	☐	☐	_____
Non Medication Allergies	☐	☐	_____

Are you currently? **Pregnant** ☐ Nursing ☐

Medical Doctor: _____

Medications: Please list **ALL Medications** you are taking, including eye drops & non-prescription drugs.

_____

_____

Do you have any allergies to medications? No ⬜ Yes ⬜ If yes, please list: _____

Social History

Do you drink alcohol? ⬜ No ⬜ Occasional ⬜ 1 per day ⬜ 2-3 per day ⬜ 4+ per day

Do you smoke? ⬜ No ⬜ ½ pack/day ⬜ 1 pack/day ⬜ 1+ pack/day

Hobbies/Interests: _____

Family History (parent or sibling): Has a family member ever had any of the following conditions?

	Yes	**No**	Please List		**Yes**	**No**	Please List
Cancer	⬜	⬜	_____	Macular Degen.	⬜	⬜	_____
Diabetes	⬜	⬜	_____	Cataract	⬜	⬜	_____
High Blood Pressure	⬜	⬜	_____	Glaucoma	⬜	⬜	_____
Thyroid Disease	⬜	⬜	_____				

Social History: Current Occupation _____ Employer _____

Contact Lens History:

Do you currently wear contact lenses? ⬜ Yes ⬜ No

If not currently a contact lens wearer, are you interested in trying contact lenses? ⬜ Yes ⬜ No

Brand of contact lenses _____

Name of Solution used _____

Please describe the comfort of your contact lenses _____

We ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Initial _____ **Payment from my insurance is to be paid directly to Pure Vision Center. I understand that Pure Vision Center will bill my insurance. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed by the insurance company.**

By signing below, I acknowledge that I received a copy of the Notice of Privacy Practices from Pure Vision Center.

Signature/Guardian _____ Date _____