HEARTLAND FAMILY EYECARE

1250 NW 128th St, Suite 150, Clive, IA 50325
Office: 515-223-9595; Fax: 515-223-9792
Email: info@heartlandfamilyeye.com

New Patient History Form

Date:_____

Name (legal): _____ **DOB:** _____

Gender: F M Marital status: _____ **Email** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: (home) _____ **(work)** _____ **(cell)** _____

Preferred method of contact. We will use this for follow-up on products or services. Mark all that apply.

Email. Phone. Text.

Insured's Name: _____ **Insured's DOB:** _____

Insured's Employer: _____

Preferred Language: English Other_____ Decline

Race: Asian American Indian or Alaska Native Black or African American

Caucasian/White Other Decline

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Tobacco Use: Current Former Never

Please list any medications you are taking, including prescription medicines, over the counter eye drops, vitamins, or supplements: None or

_____

_____

Please list any allergies to medications: None or

_____

_____

For Office Use Only

__File Medical __sched. Follow-up

__File vision __Dr's change

__screen photos __lens warranty

__order trials __frame warranty

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Family History have your parents, siblings, or children been diagnosed with any of the following: **NO to all**

Cataracts_____ Macular Degeneration_____ Glaucoma_____

High blood pressure _____Diabetes_____

Review of systems: Do you currently have any of the following?

Constitution:

___ None ___ Fatigue

___ Cancer ___ Other_____

ENT:

___ None ___ Hearing loss

___ Sinusitis ___ Dry Mouth

___ Laryngitis ___ Other_____

Neurological:

___ None ___ Multiple Sclerosis

___ Cerebral Palsy ___ Tumor

___ Stroke/CVA ___ Other_____

Psychology:

___ None ___ Depression

___ Anxiety Disorder ___ Bipolar Disorder

___ Other _____

Cardiovascular:

___ None ___ Hypertension

___ Heart Disease ___ Vascular Disease

___ Congestive Heart Disease ___

Other_____

Respiratory:

___ None ___ Cigarette smoker

___ Asthma ___ Bronchitis

___ Emphysema ___ Other_____

Gastrointestinal:

___ None ___ Crohn's Disease

___ Colitis ___ Ulcer

___ Acid Reflux ___ Celiac Disease

Genitourinary:

___ None ___ Kidney Disease

___ STD (herpetic/Chlamydia)

___ Prostate disease/Cancer ___

Other_____

Musculoskeletal:

___ None ___ Arthritis

___ Osteoarthritis ___ Osteoporosis

___ Other _____

Integumentary:

___ None ___ Eczema

___ Psoriasis ___ Cold Sores

___ Shingles ___

Other_____

Endocrine:

___ None ___ Type 1 Diabetes

___ Thyroid Dysfunction ___ Type 2 Diabetes

___ Hormonal Dysfunction ___

Other_____

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Hematologic/Lymphatic:

___ None ___ Anemia
___ Large volume blood loss ___ High Cholesterol
___ Gout ___ Other_____

Allergies/Immune:

___ None ___ Environmental
___ Medications ___ Lupus
___ Rheumatoid Arthritis ___ Other_____

Are you experiencing or have you been diagnosed with any of the following: or **NO to all**

___ Cataract ___ Glaucoma ___ Diabetic Retinopathy ___ Macular Degeneration
___ Diabetes ___ Iritis/Uveitis ___ Floaters/light flashes ___ Retina defects/degen
___ Headache ___ Total loss of vision ___ Dry eye ___ Redness
___ Burning ___ Itching ___ Discharge ___ Sensitivity to light
___ Eye pain ___ Tearing ___ Eyestrain ___ Double vision
___ Blurred vision ___ Poor night vision ___ Bothersome night glare

Please list any vision or eye concerns: **None or**

_____
_____

Please list any eye surgeries or injuries : **None or** _____

_____

Screening Retinal Photography

Retinal photography is recommended at your first exam with us as a baseline. Dr. Soults will review your photos with you during your exam and explain what she is observing. The retina is the nerve layer that lines the back of the eye, and photos will allow us to monitor for changes over time.

The fee for screening retinal photos is $30.00 and is not covered by insurance.

I have read the above information about retinal photography.

_____ (initial) YES, I choose to have retinal photos.

_____ (initial) NO, I choose to decline retinal photos.

Contact lens wearers :

** _____ (initial) **Please note that contact lens management fees are not usually covered by vision or medical insurance plans. Payment is expected on the day of service.****

Insurance Authorization (please sign below): I authorize the release of information necessary to process my claims and the payment of benefits to Heartland Family Eyecare.

Patient Signature: _____ Date:

_____

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HIPPA Privacy Practice — Please sign and date. I was offered a copy of HFE's Privacy Practices

Patient Signature: _____ Date: _____

Relationship if patient not signing:

_____ Additional

authorization: We will only share your information as outlined in our privacy policy. You can choose to allow to share information with family or friends. I give permission for HFE to release information to:

_____