HEALTH HISTORY - Woodlands Eye Associates

Name: _____ *D.O.B.*_____ *Todays Date:*_____

*Best Phone #:*_____

Last Eye Examination: _____ *By Dr.:* _____

*Referring Doctor:*_____ *Pharmacy:* _____

EYE HISTORY *Are you experiencing any of the following symptoms? Please check.*

❑ Blurred Vision	❑ Double Vision	❑ Sty	❑ Tearing	❑ Dryness
❑ Flashes/Floaters	❑ Glare	❑ Eye Lid Itch	❑ Light sensitivity	❑ Discharge
❑ Variable Vision	❑ Droopy Eyelid(s)	❑ Eyeball Itch	❑ Eye Pain	❑ Foreign Body Sensation
❑ Distorted Vision	❑ Loss of Lashes	❑ Sting, Burn	❑ Redness	❑ Other_____

Have you had any eye surgery, laser treatments or eye injury: ❑ YES ❑ NO ***If yes, please explain:*** _____

What eye drops are you using?_____ ***How often?***_____

When do you wear your glasses? ❑ All the time ❑ Computer ❑ Reading/Near ❑ Distance only ❑ Other _____

How old is this prescription?_____ ***Do you see well with this prescription?*** ❑YES ❑NO

Do you wear contacts? ❑YES ❑NO

Are you interested in contacts? ❑YES ❑NO Brand of contacts if known:_____

Are you interested in laser vision correction ❑YES ❑NO

FAMILY HISTORY *Do you or a blood relative have:*

	Self		Relative	
Glaucoma	❑YES	❑NO	❑YES	❑NO
Cataracts	❑YES	❑NO	❑YES	❑NO
Lazy Eye	❑YES	❑NO	❑YES	❑NO
Retinal Disease	❑YES	❑NO	❑YES	❑NO
Macular Degeneration	❑YES	❑NO	❑YES	❑NO
Corneal Disease	❑YES	❑NO	❑YES	❑NO
Hypertension	❑YES	❑NO	❑YES	❑NO
Cancer	❑YES	❑NO	❑YES	❑NO
COPD	❑YES	❑NO	❑YES	❑NO
Arthritis	❑YES	❑NO	❑YES	❑NO
Diabetes	❑YES	❑NO	❑YES	❑NO
Asthma	❑YES	❑NO	❑YES	❑NO

SOCIAL HISTORY *(required for insurance)*

Do you smoke: ❑ YES ❑ NO ❑ Did but quit

Have you been infected with:
❑ Hepatitis ❑ Herpes Simplex ❑ HIV ❑ None

Race:
❑ White ❑ African American/Black ❑ Asian
❑ Hispanic ❑ I decline to specify ❑ Other

Ethnicity:
❑ Hispanic ❑ Not Hispanic ❑ I decline to specify

Preferred Language:
❑ English ❑ Spanish ❑ I decline to specify

REVIEW OF SYSTEMS *(required for insurance) Place check beside the following that apply or mark NONE below:*

❑ **Constitutional** Fever, Weight gain/loss	❑ **Endocrine** Thyroid/other glands	❑ **Gastrointestinal** Colitis, Crohns disease	❑ **Lymphatic/Hematologic** Anemia/Bleeding
❑ **Ear/Nose/Throat** Hearing loss, Sinus	❑ **Respiratory/Pulmonary** Asthma, Bronchitis	❑ **Genitourinary** Bladder/Prostate	❑ **Allergic/Immunologic** Sjogrens
❑ **Neurological** Migraines	❑ **Cardiovascular, Vascular** Blood pressure	❑ **Bones/Joints** Joint Pain/Arthritis	❑ **Psychiatric** Depression

Please list any surgeries_____ ❑ **NONE**

MEDICAL HISTORY

Are you allergic to any medications ❑ Yes ❑ No Known Please list _____

Please check if any of the following pertain to you:

❑ Pulmonary Disease ❑ Heart Problems ❑ Pregnant /Nursing ❑ None Height_____ Weight _____

List any medications including sleep aids, allergy/cold, birth control, etc.: _____

GENERAL HEALTH *Do you feel that your general health is* ❑ Good ❑ Fair ❑ Poor

1001 Medical Plaza Dr. Ste. 100
The Woodlands, TX 77380
281.367.2020

Woodlands Eye ASSOCIATES

Panther Creek Shopping Center
The Woodlands, TX 77381
281.367.5335

Patient Information

Thank you for choosing our practice for your eye care needs. Please complete this form. If you have any questions or concerns, do not hesitate to ask for assistance.
(Please Print, if completing in the office.)

Date: _____

Last Name: _____

First Name: _____ MI _____

Title: ❑ Miss ❑ Mrs ❑ Mr. ❑ Dr.

Nickname: _____

Address: _____

City: _____

State:_____ Zip:_____

Sex: ❑ Male ❑ Female Age: _____

Birthdate: _____

Marital Status: ❑ Minor ❑ Married ❑ Single

Employment Status: _____

Employer: _____
(Parents Employer)

Occupation: _____

Referred by: _____

Email: _____

Best Phone Contact: _____

Insurance Information

Vision insurance is used for routine eye exams for glasses or contact lenses and includes VSP, Superior Eyemed, ECPA and Block. However, it does not cover medically related problems or complaints.

Medical insurance will cover medical problems or complaints such as dryness, redness, itch, burn, eye pain, floaters, headaches, glaucoma, cataracts and more. We will bill your medical insurance company on your behalf. We accept most medical insurances including Medicare.

By providing all insurance information we are better able to bill the appropriate insurance in your behalf and better serve you as our patient.

Vision Insurance: _____ ID# _____ Group# _____

Medical Insurance: _____ ID# _____ Group# _____

Responsible Person for Insurance, if other than the Patient

(If you are the patient and the Primary on the insurance you do not need to complete this portion.)

Last Name: _____ First Name: _____ MI: _____ Sex: ❑ M ❑ F

Title/Suffix: ❑ DDS. ❑ Jr. ❑ Sr. ❑ MD ❑ I ❑ II ❑ III DOB: _____

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____

Daytime Phone: _____

SSN: _____

Employer: _____

Authorization

I certify I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me - I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and that of my dependents.

X_____

SIGNATURE OF PATIENT *(Or parent if minor)* DATE