Tucson Family Vision Care Patient History Form *– Please print out and complete before your appointment*

Patient Name: □ Mr. □ Mrs. □ Ms. _____ Today's Date:_____/_____/_____

Address: _____ Phone: _____

City: _____ State: _____ Zip:_____ Cell Phone: _____

Guardian (if applicable): _____ Email: _____

Last 4 of SS#: _____ Birthdate: _____/_____/_____ Occupation _____ Hobbies: _____

Last Eye Exam _____/_____/_____ From Dr: _____ Last Medical Exam _____/_____/_____ From Dr: _____

Vision Insurance _____ ID#:_____ Insured:_____ DOB:_____

Primary Medical Insurance: _____ ID#: _____ Insured:_____ DOB:_____

Secondary Medical Insurance: _____ ID#: _____ Insured:_____ DOB:_____

In compliance with HIPAA regulations all information will be kept strictly confidential. *Please read and sign below:*

I have received a copy of the *Tucson Family Vision Care - Notice of Privacy Practices*. I authorize payments of benefits to Tucson Family Vision Care and/or Mike Wu O.D., P.C. I agree to be financially responsible for any balance not paid by my insurance plan.

Patient or Responsible Party: _____Date: _____/_____/_____

Medical History

List all medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

_____

Allergies? ❒ None ❒ Penicillin ❒ Sulfa ❒ Seasonal ❒ Other: _____
Are you pregnant and/or nursing? ❒ No ❒ Yes Weeks pregnant _____
Do you wear glasses? ❒ No ❒ Yes Age of current pair? _____
Do you wear contact lenses? ❒ No ❒ Yes Type/Brand? _____ Replaced how often? _____

Family History: Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

❒ Blindness ❒ Cataract ❒ Crossed Eyes ❒ Glaucoma ❒ Macular Degeneration ❒ Retinal Detachment/Disease
❒ Diabetes ❒ Hypertension ❒ Heart Disease ❒ Cancer ❒ Thyroid Disease ❒ Autoimmune Disorders

Relation:_____

Social History – *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

❒ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? ❒ No ❒ Yes If yes, do you have visual difficulty when driving? ❒ No ❒ Yes If yes, please describe:

_____

Do you use tobacco products? ❒ No ❒ Yes If yes, type/amount/how long: _____
Do you drink alcohol? ❒ No ❒ Yes If yes, type/amount/how long: _____
Do you use illegal drugs? ❒ No ❒ Yes If yes, type/amount/how long: _____

Review of Systems: Mark the box if you currently, or have you ever had, any problems in the following areas:

Personal Ocular History:	❒ Cataracts	❒ Glaucoma	❒ Eye Surgery	❒ Crossed Eyes	❒ Lazy Eye	❒ Macular Degeneration
	❒ Eye Injury	❒ Eye Infections	❒ Double Vision	❒ Droopy Lid	❒ Keratoconus	❒ Retina Problems
Personal Medical History:						
Eyes	❒ Loss of Vision	❒ Itching	❒ Burning	❒ Tearing	❒ Redness	❒ Loss of Side Vision
	❒ Blurred Vision	❒ Dryness	❒ Flashes	❒ Floaters	❒ Color Deficient	❒ Glare/Light Sensitivity
Endocrine	❒ Diabetes 2	❒ Diabetes 1	❒ Thyroid		❒ Other: _____	
Cardiovascular	❒ Stroke	❒ Hypertension	❒ Heart Disease	❒ Cholesterol	❒ Other: _____	
Constitutional	❒ Cancer	❒ Chronic Fatigue	❒ Developmental Disorders		❒ Other: _____	
Respiratory	❒ Asthma	❒ Emphysema	❒ Bronchitis		❒ Other: _____	
Allergic/Immunologic	❒ Rhm. Arthritis	❒ Lupus	❒ Sjogren's		❒ Other: _____	
Ears, Nose, Mouth, Throat	❒ Runny Nose	❒ Sinus Problems	❒ Dry Mouth	❒ Chronic Cough	❒ Other: _____	
Integumentary (Skin)	❒ Cold Sores	❒ Shingles	❒ Rosacea	❒ Psoriasis	❒ Other: _____	
Musculoskeletal	❒ Arthritis	❒ Muscle Pain			❒ Other: _____	
Neurological	❒ Migraines	❒ Seizures	❒ MS	❒ Brain Tumor	❒ Other: _____	
Gastrointestinal/Urinary	❒ Crohn's	❒ Colitis	❒ Kidney Disease		❒ Other: _____	
Lymphatic/Hematologic	❒ Anemia	❒ Bleeding Problems			❒ Other: _____	
Psychiatric	❒ Depression	❒ Bipolar	❒ Anxiety	❒ ADD/ADHD	❒ Other: _____	

If you answered YES to any of the above or have a condition not listed, please explain below:

_____

Doctor's Signature _____ Date: _____/_____/_____

Above signature indicates doctor has reviewed this entire medical history questionnaire