# PATIENT HISTORY

Date___________Name______________________________Date of Birth_____________Age_____**Cell ph**________________________

Address_________________________________City/State/Zip_________________________________Home ph______________________

**Email**________________________________________May we contact you by text/email? □Yes □No Parent/guardian___________________

Family Dr________________________Occupation__________________ _Hobbies/Sports/Visual Needs_____________________________

Who may we thank for referring you to us?______________________When/where was your last eye exam?__________________________

Reason for Visit Today____________________________________________________

Currently wear: □ Glasses □ Contact lenses, if yes, brand______________________ Are you interested in contact lenses? □ No □ Yes

**Current Eye Symptoms:**

□ Distance vision blurred □ Double vision □ Dry eyes □ None, routine exam
□ Near vision blurred □ Red eyes □ Itchy eyes □ Other/comments______________________________
□ Eyestrain □ Burning eyes □ Watery eyes

**Eye History**: (check those that apply to YOU)

□ Glaucoma □ Cataracts □ Macular degeneration □ Eye injury □ Eye surgery □ Other____________________________________

**Personal Medical History**: (check those that apply to YOU)

□ Psychiatric disorder □ Heart/cardiovascular disease □ Diabetes
□ Arthritis/bone problem □ High Blood Pressure □ Neurological (MS, migraines): type__________________
□ Allergies □ Blood problem: type___________________ □ Breathing/lung problem: type________________________
□ Thyroid disease □ Skin disease: type_____________________ □ Other__________________________________________

**Family History**: (check those that apply to your blood relatives)

□ Diabetes □ Glaucoma □ Retinal detachment □ Macular degeneration □ Other eye disease___________________

Please list any medications you are taking:_________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________

Are you allergic to any medications? □ No □ Yes:________________________________________

Do you smoke? □ No □ Yes

Are you pregnant? □ No □ Yes

**HIPAA NOTICE**

I have seen (on the wall) or been offered a copy of the HIPAA Privacy Notice.

Sign:____________________________________________________

**CONSENT TO BILL INSURANCE**

I authorize this office to bill and collect payment for services rendered to me and to use a photocopy of my signature. I understand I am financially responsible for all non-covered services.

Sign:____________________________________________________

**EYE DILATION**

The doctor may need to give you some mild eye drops to allow him/her to check for eye diseases and prescribe the most accurate prescription. The eye drops temporarily make you more light sensitive and make your near vision blurry. Distance vision is not usually affected. Sunglasses will be provided. **Please initial:**

_____ It is OK to dilate my eyes. ______ I do not want my eyes dilated. Sign:____________________________________________________

**FOR CONTACT LENS WEARERS**

Contact lenses are medical devices available by prescription only. As with any drug or device, contact lens wear is not without risk. There is a small but significant risk of serious complications associated with contact lens wear. If you experience any pain, redness, discharge, loss of vision or light sensitivity, remove your contacts immediately and call our office or another eye specialist.

Sign:____________________________________________________