

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, 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
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Eye Infection	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degen	<input type="checkbox"/>	<input type="checkbox"/>	Floaters/Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Iritis or Uveitis	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Poor Night Vision	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Retina Defects	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Night Glare	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	Eyestrain	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	Total Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat Problems (hearing loss, sinus problems, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic Problems (MS, seizures, headaches, Parkinson's, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Problems (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (High blood pressure , heart attack, stroke, pacemaker)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (Asthma, Chronic bronchitis, Lung disease, Sleep Apnea)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (Heartburn, ulcers, liver/hepatitis, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary (Kidney, bladder, or prostate disease)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal (Rheumatoid Arthritis, muscle pain, joint pain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin/Integumentary (Acne rosacea, rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine Problems (Diabetes , thyroid disease)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/Lymph (high cholesterol , anemia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non Medication Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you currently? Pregnant <input type="checkbox"/> Nursing <input type="checkbox"/>			

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 1/2 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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular Degen	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Social History: Current Occupation _____ Employer _____

Visual History

Do you use a computer? Yes No
Do you drive? Yes No
Do you have difficulty driving? Yes No
Do you have night glare problems? Yes No
Do you wear Sunglasses? Yes No Transition Lenses

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 _____

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. 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. Payment from my insurance is to be paid directly to Pure Vision Center. I understand that Pure Vision Center will bill my primary insurance and any secondary insurance is my responsibility. I understand that all benefits are 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 signing below, I acknowledge that I received a copy of the Notice of Privacy Practices from Pure Vision Center.

Signature/Guardian _____ Date _____