# WELCOME TO EYEDESIGNS OPTOMETRY

Thank you for choosing our office for your eye care needs. Please fill out this entire patient medical history form and sign the bottom.

**Name**: ______________________________ **Title**: Mr. Ms. Mrs. Dr. **Today's Date**:__________
Last First MI

**Nickname / AKA** __________ ☐ Male ☐ Female **Date of Birth**:__________ **Social Security #:**__________

**Mailing Address**:__________ **City**:__________ **State**:______ **Zip**:______

**Cell Phone**:__________ **Home Phone (optional)**:__________ **E-Mail** :__________

**Preferred Method of Notification**: ☐ Text Message ☐ Email ☐ Phone Call ☐ Post Card

**Occupation (or if student, Grade Level)**:__________ **Employed by (or if student, School)**:__________

**Marital Status**: ☐ Single ☐ Married ☐ Domestic Partner ☐ Minor- Name of Responsible Parent:__________

**In case of emergency, contact**: __________ Relationship:__________ Phone:__________

**Vision Benefits**: ☐ VSP (Vision Service Plan) ☐ None ☐ Other:__________

**Primary Care Physician**:__________ Phone or City__________ Last Exam Date:__________

**Health Insurance:**__________ **Member ID (if known):**__________

**How did you hear about our office**? ☐ Insurance List ☐ Internet ☐ Yelp ☐ Referred By:__________

## PERSONAL & FAMILY EYE / MEDICAL HISTORY

**Date of Last Eye Exam**:__________ **Purpose for today's visit**:__________

**Do you wear glasses?** ☐ No ☐ Yes Age of your present glasses?______ **Do you wear Contact Lenses**? ☐ No ☐ Yes ☐ Interested

**Do you use a computer?** ☐ No ☐ Yes, Hours per day?_____ **Do you use a mobile device (phone, iPad, Kindle)?** ☐ No ☐ Yes, Hours per day?_____

**Please list important Visual Chores/Hobbies/Gaming/Sports**:__________

__________

**Do you have any allergies (medicines, food, pollen, animals)?** ☐ No ☐ Yes, Please List:__________

**List your medications** (include non-prescription, birth control, homeopathic & vitamins):__________

__________

**List any major injuries or surgeries:**__________

**Do you currently, or have you had any health conditions in the following systems? Please check all that apply:**

| Constitutional | Respiratory | Genitourinary | Bones/Joints/Muscles | Lymphatic/Hematologic |
|---|---|---|---|---|
| ☐ Fever/Wt.Gain or loss | ☐ Asthma | ☐ kidney/bladder | ☐ Rheumatoid Arthritis | ☐ Anemia/bleeding |
| Integumentary | ☐ COPD | Ears, Nose, Mouth, Throat | ☐ Joint or Muscle Pain | Psychiatric |
| ☐ Skin | ☐ Emphysema | ☐ Hearing Loss/Tinnitus | ☐ Neck, Back, Lumbar Issues | ☐ Depression |
| Neurological | Endocrine | ☐ Sinus Congestion | Vascular/Cardiovascular | ☐ Anxiety |
| ☐ Headaches | ☐ Thyroid | ☐ Dry Throat/Mouth | ☐ Heart Disease | ☐ Other__________ |
| ☐ Migraines | ☐ Diabetes | Allergic/Immunologic | ☐ Hypertension | Other |
| ☐ Seizures | Gastrointestinal | ☐ Allergy/Hay fever | ☐ High Cholesterol | ☐ Cancer: __________ |
| ☐ Tumor | ☐ IBS/Crohn's/UC | ☐ AIDS/HIV/Hepatitis | ☐ Stroke | ☐ Currently Pregnant? |

If you checked yes to any of the above, please explain:__________

__________

**Do you or any of your blood relatives have any of the following conditions that affect vision? Please check and state relationship to you**

| | | |
|---|---|---|
| ☐ Blindness__________ | ☐ Glaucoma __________ | ☐ Retinal Disease/Detachment__________ |
| ☐ Cataracts__________ | ☐ Macular Degeneration__________ | ☐ Double Vision__________ |
| ☐ Dylexia/Learning__________ | ☐ Corneal Disease/Dystrophy__________ | ☐ Crossed or Lazy Eye __________ |
| ☐ Eye Injury/Infection__________ | ☐ LASIK/PRK__________ | ☐ Cancer/Type__________ |
| ☐ High Blood Pressure__________ | ☐ Diabetes__________ | ☐ Other:__________ |

## SOCIAL HISTORY

***This information is strictly confidential.*** Please fill out as completely as possible. However, if you wish to discuss these questions directly with the doctor, leave the questions unanswered and check this box: ☐ I would prefer to discuss my Social History information directly with the doctor.

**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/social drugs?** ☐ No ☐ Yes If yes, type/amount/how long?:__________
**Have you ever been exposed to infectious disease?** ☐ No ☐ Yes If yes, please indicate (HIV, Hepatitis, Syphilis, etc.):__________

## AUTHORIZATION / RECEIPT OF PRIVACY PRACTICES (HIPAA)

I, the undersigned, declare, to the best of my knowledge, the above to be true. I understand that I am financially responsible for all services provided by the doctors and staff of EyeDesigns Optometry to me (or my dependent), whether or not paid for by insurance. I hereby authorize the release of any medical information necessary and the use of my signature to process my insurance claims; I authorize payment of insurance benefits to include basic and major medical benefits to either myself or the party who accepts assignment with my insurance company; and lastly, I acknowledge that I have read/received a copy of the EyeDesigns Optometry Notice of Privacy Practices.

Date:__________ Signature of Patient or Responsible Party:__________