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

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

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

Home Ph: __________ **Work Ph:** __________ **Cell Ph:** __________ **E-Mail :** __________

Preferred Method of Notification: ☐ Text Message ☐ Email ☐ Cell Phone ☐ Home Phone ☐ Post Card

Occupation / Grade Level: ______________________ **Employed by / School:** ______________________

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

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

Vision Insurance: ☐ VSP (Vision Service Plan) ☐ Medicare ☐ None ☐ Other: __________

Primary Care Physician: __________ Phone or City __________ Last Exam Date: __________

Health Insurance: __________ **Member ID/Medicare #** __________

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? ____ **Please list important Visual Chores/Hobbies/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
- ☐ Fever/Wt.Gain or loss

Integumentary
- ☐ Skin

Neurological
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Tumor

Respiratory
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema

Endocrine
- ☐ Thyroid
- ☐ Diabetes

Gastrointestinal
- ☐ Diarrhea

Genitourinary
- ☐ kidney/bladder

Ears, Nose, Mouth, Throat
- ☐ Sinus Congestion
- ☐ Dry Throat/Mouth

Allergic/Immunologic
- ☐ Allergy/Hay fever
- ☐ AIDS/HIV/Hepatitis

Bones/Joints/Muscles
- ☐ Rheumatoid Arthritis
- ☐ Joint or Muscle Pain

Vascular/Cardiovascular
- ☐ Heart Disease
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Vascular Disease

Lymphatic/Hematologic
- ☐ Anemia/bleeding

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Other __________

Other
- ☐ Pregnant

If you answered 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 __________
- ☐ Cataracts __________
- ☐ Eye Injury/Infection __________
- ☐ High Blood Pressure __________
- ☐ Glaucoma __________
- ☐ Macular Degeneration __________
- ☐ Eye Surgery __________
- ☐ Diabetes __________
- ☐ Retinal Disease/Detachment __________
- ☐ Crossed or Lazy Eye __________
- ☐ Cancer/Type __________
- ☐ 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

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; and 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.

Date: __________ Signature of patient or responsible party: __________