Health History

Date _____ Name _____

Date of Birth _____ ☐ Male ☐ Female

Date of Last Exam _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you wear glasses? ☐ Y ☐ N Contacts? ☐ Y ☐ N How long? _____

Please provide information of any other physician to whom you would like us to send a written report

Physician Name _____ Fax _____

Office Address _____ Telephone _____

City _____ State _____ Zip _____

Reason for your visit today _____

_____

_____

_____

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	☐	☐	_____
Ear/nose/throat (hearing loss, sinus problems, sore throat)	☐	☐	_____
Heart (chest pain, irregular heart beat, blood pressure)	☐	☐	_____
Respiratory (shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	_____
Urinary (pain or discomfort, blood in urine)	☐	☐	_____
Skin (excessive dryness)	☐	☐	_____
Musculoskeletal (muscle aches, joint pain, swollen joints)	☐	☐	_____
Neurologic (numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric (depression, anxiety)	☐	☐	_____
Endocrine (diabetes, thyroid disease)	☐	☐	_____
Cancer	☐	☐	_____

Health History

Your Ocular History

Do you CURRENTLY have any of the following problems?

Yes	No		Yes	No		Yes	No	
☐	☐	Cataracts ☐ Right Eye ☐ Left Eye	☐	☐	Double Vision	☐	☐	Glaucoma
☐	☐	Corneal Disease	☐	☐	Macular Degeneration	☐	☐	Iritis
☐	☐	Crossed Eyes, Lazy Eye	☐	☐	Eye Infections	☐	☐	Retina disease
☐	☐	Floaters or Flashing Lights	☐	☐	Other Eye Disorders			
☐	☐	Have you ever had laser surgery?	☐	☐	Have you ever had an eye injury?			
☐	☐	Have you ever had eye surgery?						

Please explain any YES answers from above _____

_____

_____

_____

Please list any ALLERGIES you may have _____

_____

_____

_____

List ALL medications - prescriptions and non-prescription - you are currently taking

1 _____	5 _____	9 _____
2 _____	6 _____	10 _____
3 _____	7 _____	11 _____
4 _____	8 _____	12 _____

Pharmacy Name _____ Pharmacy Phone Number _____

Surgical History

Please include date and type of surgery

☐ None

_____

_____

_____

_____

_____

Health History

Family History/Social History

Has anyone in your family (blood relative) had any of the following?

Yes	No		Yes	No	
☐	☐	Glaucoma	☐	☐	Diabetes
☐	☐	Cataracts	☐	☐	Heart Disease
☐	☐	Crossed Eye / Lazy Eye	☐	☐	Diabetic Retinopathy
☐	☐	Stroke	☐	☐	Other Eye Problems
☐	☐	Corneal Disease	☐	☐	Other Diseases
☐	☐	Rheumatoid Arthritis/ Autoimmune disease	☐	☐	Macular Degeneration

☐ ☐ Do you smoke?
☐ ☐ Drink alcohol?
☐ ☐ If employed how many hours per week do you work?
☐ ☐ Does your employment contribute to any stress in your life?

Please explain any YES answers from above _____

_____

_____

_____

I certify that the statements are true to the best of my knowledge.

Patient Signature _____ Date _____

Physician Signature _____ Date _____

REFRACTION SERVICES AND FEES

A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of the eye exam and is necessary to write a prescription for glasses or contact lenses.
A refraction is NOT a covered service by Medicare or most medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service.

We will NOT file the charge for a refraction with a health insurance unless we know that your plan covers the refraction charge.

Our office fee for a refraction is $60 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

We cannot file insurance on both the medical and routine vision plan for the same visit.

_____ _____
Patient's Name (printed) **Date**

_____ _____ _____
Patient Signature (Legally responsible applicable) **Relationship to patient** **Staff Witness**