MEDICAL HISTORY

Name:____ Age: _________

Last eye exam: ____ /____ /___ Last medical exam: ___ /___ /___ Primary care physician: ____________________

Ocular History:

Reason for today's visit ____

____

1) Do you wear glasses? ☐ Yes ☐ No
2) Have you worn contact lenses? ☐ Yes ☐ No Are you interested in contacts? ☐ Yes ☐ No
3) Do you work on a computer? ☐ Yes _______hours/day ☐ No
4) Have you ever had any of the following (check all that apply): ☐ Lazy eye ☐ Crossed eye/turn ☐ Injury of the eye ☐ Infection of the eye ☐ Eye surgery ☐ Glaucoma ☐ Cataracts ☐ Macular degeneration ☐ Retinal disease ☐ Other: ____
5) Are you followed by an ophthalmologist? ☐ No ☐ Yes, Name of provider:______________________________

Ocular Symptoms:

6) Have you experienced any of the following (check all that apply): ☐ blurred distance vision ☐ blurred near vision ☐ eye strain ☐ headaches ☐ redness ☐ itching ☐ burning/irritation ☐ pain ☐ watering ☐ flashes of light ☐ floaters ☐ double vision ☐ vision loss

Review of Symptoms:

7) Do you have any of the following medical conditions (check all that apply): ☐ Migraines ☐ Seizures ☐ Asthma ☐ Seasonal allergies ☐ Emphysema ☐ Diabetes ☐ High blood pressure ☐ Heart disease ☐ COPD ☐ Vascular disease ☐ Gastrointestinal problems ☐ Muscle/joint pain ☐ Anemia/blood disorder ☐ Thyroid disease ☐ Arthritis ☐ Kidney/bladder problems ☐ Inflammatory disease ☐ Psychiatric disorder ☐ Cancer ☐ High cholesterol ☐ HIV +

Medical History:

1) Are you allergic to any medications? ☐ Yes ☐ No
   If yes, please list:____
2) List any medications you take (please include over the counter as well oral contraceptives): ______________________
   ____
   ____
3) List any medical conditions you are currently being treated for: ____
   ____

Social History:

4) Do you smoke? ☐ Yes ☐ No 5) Do you consume alcoholic beverages? ☐ Yes ☐ No

Family Medical History (check all that apply): ☐ Lazy eye ☐ Cataracts ☐ Glaucoma ☐ Macular degeneration ☐ Retinal disease ☐ Retinal detachment ☐ High blood pressure ☐ Diabetes ☐ Thyroid disease ☐ Arthritis ☐ Cancer

Completed by/patient's initials: ____________ Date_____________ Reviewed by Dr: _____________

PERSONAL INFORMATION

First Name: ____________________________ Middle Initial: __ Last Name: ____

Date of Birth: _________/_______/_______ Social Security: _________-________-______________

Address: ____

City: ____ State: _________________ Zip: ____________

Primary Phone: _______________________________ Secondary Phone: ______________________________

Email: ____

Emergency Contact: ____________________________ Relationship to Patient: ________________________________

Phone: _______________________________________

Method of Payment: **CASH / CHARGE / TRICARE**

DILATION EDUCATION & CONSENT FORM (MUST SIGN)

Dilation is an important part of a routine eye exam and is strongly recommended yearly. Dilation allows the doctor to see thoroughly the back (retina) of the eyes, and purpose is for detection of diseases.

It is HIGHLY recommended for patients with a history of diabetes, high blood pressure, headaches, migraines, floaters, flashing lights, high spectacle prescriptions, retinal problems, glaucoma, or a family history of eye disease.

This procedure will add an additional 30-45 minutes to your exam. Afterwards, some patients may experience blurred vision especially while reading and may have an increased sensitivity to light. These side effects may last for approximately 3-4 hours. Driving is usually not impaired, but may require extra attention.

ALL DIABETICS WILL BE DIALTED UNLESS THEY BEEN PREVIOSULY DILATED LESS THAN 1 YEAR AGO.

Please check one: Accept _________ Decline ________

Signature of Responsible Party: ____ Date: ______________________

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECIEPT

Effective Date of Notice: 02/01/2021

This is to certify that the office of Optometric Services, PLLC. has advised me that the NOTICE OF PRIVACY PRACTICES is available for my review at the front desk. I authorize the release of any medical or personal information necessary in order to process this claim through my insurance, if applicable, or in the case of any medically necessary referral to another health professional. I certify that the insurance information I have reported with regard to my coverage is correct. I agree to assume responsibility for full payment pending any remaining balance that is not covered by insurance company.

I acknowledge that I have received said notice.

Patient or Guardian Name: ____

Signature: ____

Date: ____

Required by HIPAA