olatheeyecare

PATIENT HISTORY FORM

First Name: _____ M.I._____ Last Name: _____ Sex: M F

Date of Birth: _____ Parent/Guardian Name (if under 18): _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ (☐Cell ☐Home ☐Work)

Email: _____

Employer/ Occupation: _____

VISION INSURANCE

Insurance Company: _____ Member ID #: _____

Subscriber Name: _____Subscriber Date of Birth: _____

Subscriber Social Security #: _____

MEDICAL INSURANCE

Insurance Company: _____ Member ID #: _____

Subscriber Name: _____Subscriber Date of Birth: _____

Subscriber Social Security #: _____

**__All charges incurred are due at the time of service__ unless we are a participating provider of your insurance and arrangements have been made prior to your exam. If we are not a participating provider of your insurance, we would be happy to provide you with an itemized bill which you may submit to your insurance company for any reimbursement due.*

(If New Patient) How were you referred to our clinic?

Website _____Insurance Listing _____ Friend/Relative _____ Other _____

REASON FOR TODAY'S VISIT (Check all that apply)

☐Routine Eye Exam ☐Glasses ☐Contact Lenses ☐Change in Vision

☐Diabetic Eye Exam ☐Red/Painful Eye ☐Dry Eye ☐Other _____

(If New Patient) Date of Last Exam: _____ By Whom/Location:_____

Do you currently wear (*circle)*: Glasses Contacts Both

What type and brand of contacts do you wear?: _____

__Are you diabetic__? ❑Yes (circle) Type 1 Type 2 ❑No

(Women) __Are you pregnant or nursing__? ❑Yes ❑No If pregnant, how far along are you? _____

CURRENT MEDICATIONS including over-the-counter meds, oral contraceptives, and supplements:

(If available, you may provide a list to be copied in lieu of listing medications.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PATIENT MEDICAL HISTORY / REVIEW OF SYSTEMS

Do you currently have, or have you ever had, any problems in the following areas (check any that apply):

Constitutional
❑Cancer ❑Developmental Disabilities
❑Weight Loss ❑Weight Gain

Ear, Nose, Mouth
❑Hearing Loss ❑Sinusitis

Neurological
❑Migraines ❑Multiple Sclerosis ❑Stroke
❑Cerebral Palsy ❑Epilepsy ❑Autism ❑Dementia

Psychiatric
❑Depression ❑ADD ❑Anxiety ❑Bipolar

Cardiovascular
❑High Blood Pressure ❑Stroke ❑Heart Disease

Respiratory
❑Cigarette Smoker ❑Asthma ❑Bronchitis
❑Sleep Apnea ❑Emphysema ❑COPD

Gastrointestinal
❑Crohn's ❑Colitis ❑Acid Reflux ❑Celiac Disease

Genitourinary
❑Kidney Disease ❑STD ❑Prostate Disease

Musculoskeletal
❑Arthritis ❑Muscular Dystrophy ❑Fibromyalgia
❑Gout ❑Osteoporosis

Skin
❑Shingles ❑Cold Sores ❑Rosacea ❑Eczema
❑Psoriasis

Endocrine
❑Diabetes ❑Hyperthyroidism ❑Hypothyroidism

Hematologic
❑High Cholesterol ❑Anemia

Immune
❑Rheumatoid Arthritis ❑Lupus ❑Sjogren's Syndrome

If you have medical conditions not listed above, please explain: _____

_____

_____

SMOKING STATUS

❑Never Smoker ❑Former Smoker ❑Current Some Days Smoker ❑Current Every Day Smoker ❑Other _____

ALLERGIES

Drug/Medication Allergies: _____ ❑ None

Other Allergies: ❑Seasonal ❑Environmental ❑Food ❑Latex ❑Pet Dander ❑Other _____

PATIENT (SELF) OCULAR HISTORY

Disease/Condition	Yes	No	Disease/Condition	Yes	No
Glaucoma	❑	❑	Lazy Eye	❑	❑
Cataract	❑	❑	Retinal Detach/Disease	❑	❑
Macular Degeneration	❑	❑	Keratoconus	❑	❑
Eye Surgery	❑	❑	Eye Injury	❑	❑
Patching	❑	❑	Dry Eye	❑	❑
Crossed Eyes	❑	❑	Other _____		

FAMILY MEDICAL/OCULAR HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	Yes	No	Relationship	Disease/Condition	Yes	No	Relationship
High Blood Pressure	❑	❑	_____	Cataract	❑	❑	_____
Diabetes	❑	❑	_____	Glaucoma	❑	❑	_____
Cancer	❑	❑	_____	Macular Degeneration	❑	❑	_____
Thyroid	❑	❑	_____	Crossed Eyes	❑	❑	_____
Other _____			_____	Retinal Detachment	❑	❑	_____
				Other _____			_____

We are required by law to maintain the privacy of, and provide individuals with, the notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 913-764-3937.

Signature below is acknowledgement that you have read the Notice of our Privacy Practices:

Signature: _____ Print Name: _____ Date: _____