Patient History Form

(Please Print)

NAME	EMAIL ADDRESS	MALE FEMALE	BIRTH DATE	OCCUPATION
STREET	CITY	STATE	ZIP	PHONE

What is the main reason for your visit?

Do you wear glasses? ☐Y ☐N
If yes, do you wear them for: DIST, NEAR, BOTH
Do you wear contact lenses? ☐Y ☐N
Date of your last eye exam? _____
Date of your last medical exam? _____
Do you have any allergies to medication? ☐Y ☐N
LIST:
_____
_____
Do you suffer from headaches? ☐Y ☐N
Do you suffer from seasonal allergies? ☐Y ☐N
Are you taking any medications? ☐Y ☐N
Are you Pregnant? ☐Y ☐N

Do you see flashes of lights in your eyes? ☐Y ☐N
Do you see floating objects in your eyes? ☐Y ☐N
Do you suffer from temporary blackouts of your vision? ☐Y ☐N

LIST MEDS:
_____
_____
_____
_____
_____

LIST EYE MEDS:
_____
_____
_____
_____
_____

Do you suffer from:

- ☐ NONE
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Lung Disease
- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ HIV

Have your eyes ever suffered from:

- ☐ NONE
- ☐ Strabismus (eye turn)
- ☐ Amblyopia (lazy eye)
- ☐ Keratoconus
- ☐ Glaucoma
- ☐ Diabetic Retinopathy
- ☐ Macular Degeneration
- ☐ Dry Eyes
- ☐ Iritis
- ☐ Retinal Detachment
- ☐ Retinal Disease
- ☐ Optic Nerve Disease

Have you had previous eye surgery for:

- ☐ NONE
- ☐ Cataract
- ☐ Retinal Detachment
- ☐ Muscle Surgery
- ☐ Trauma
- ☐ Lasik/PRK
- ☐ Foreign Body Removal
- ☐ Other

Has anyone in your family suffered from:

- ☐ NONE
- ☐ Blindness
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Keratoconus

Doctor Initials: _____

Acknowledgement of Receipt HIPAA

I acknowledge that I have received or been offered the HIPAA Notice of Privacy Practices which describes the uses and disclosures of my protected health information by the Practice and informs me of my rights with respect to my protected health information.

Patient or Guardian (if under 18 years old) Signature: _____ **Date:** _____

Acknowledgement of Informed Consent

Safety, Sports & Children's Glasses: Polycarbonate and Trivex are considered the safest lens materials for children and for people involved in sports or other activities that involve danger of impact to the eyes and face. **Acknowledgement:** By signing this form, I acknowledge that I understand this safety notation and have answered all of the questions above to the best of my abilities.

Patient or Guardian (if under 18 years old) Signature: _____ **Date:** _____

➢ *If patient refused or could not sign, staff member should sign his or her own signature and reason above.*