Patient Information

Some of the information asked for on this form may not seem relevant to your visit today. However, many health conditions and medications affect eye health, and most insurance companies require this type of health history. **All information provided will remain confidential and will be used in accordance with HIPAA regulations.**

Today's Date: _____

Name:_____Date of Birth:_____ Age:_____

Mailing Address: _____

City/ State/ Zip code:_____

Home Phone: _____Cell Phone:_____

Work Phone:_____Email Address: _____

Occupation: _____ Employer: _____

SSN (required for insurance): _____ Marital Status: Single Married Divorced Widowed

Vision/Medical Health Insurance: _____

Primary on insurance/ Parent/ Guardian Name (if minor): _____

Primary on insurance - SSN & DOB (required for insurance): _____

Eye History:

Date of Last Eye Exam: _____Previous Eye Doctor: _____
Do you currently wear/have you ever worn contact lenses? Y☐ N☐ If yes, what type? _____
Do you sleep in lenses? Y☐N☐ How often do you discard your lenses? _____
What type of solution do you use?_____ If not, are you interested in contacts? Y☐N☐

Reason for Today's visit: _____

Have you ever been diagnosed or treated for:

- ☐ Cataract
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ LASIK/RK
- ☐ Eye Turn (In/Out)
- ☐ Lazy Eye
- ☐ Eye Injury
- ☐ Eye Surgery
- ☐ Other _____

Are you currently experiencing:

- ☐ Blurry Vision
- ☐ Itching
- ☐ Tearing
- ☐ Burning
- ☐ Increased Glare
- ☐ Flashes of Light
- ☐ Increased Floaters
- ☐ Headaches
- ☐ Double Vision
- ☐ Other _____

Family History
Please list any family members (parents, grandparents, siblings, and children) with the following conditions:

- ☐ Blindness _____
- ☐ Cataracts_____
- ☐ Diabetes_____
- ☐ Eye Turn In/Out_____
- ☐ Glaucoma _____
- ☐ Hypertension _____
- ☐ Lazy Eye _____
- ☐ Macular Degeneration _____
- ☐ Retinal Detachment _____

Eye Dilation Warning
As part of the examination, it may be necessary to dilate the pupils of the eye. This will cause some temporary blurred vision and light sensitivity for up to four or five hours. We advise that you exercise caution in operating any equipment or machinery, including driving, until the effects of the drops have worn off. If you do not want your eyes to be dilated, please discuss this with the doctors.

Medical History & Review of Systems

Primary Care Physician Name/Location: _____

Do you currently take any medication? Y☐N☐If yes, please list below, or provide a printed list to the front desk.

_____

_____

Are you allergic to any medications? ☐ No ☐ Yes If yes, which? _____

Major Surgeries: _____

Women: Are you pregnant or nursing? ☐ No ☐ Yes

Are you currently being treated for or have problems in the following areas? -or- ☐ **No current health problems**

Constitutional:
- ☐ Weight Gain/Loss
- ☐ Fever
- ☐ Fatigue
- ☐ Cancer

Cardiovascular:
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ High Cholesterol

Endocrine:
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Thyroid Dysfunction

Allergic/Immunologic:
- ☐ Seasonal Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus

Neurological:
- ☐ Headache
- ☐ Seizures
- ☐ Multiple Sclerosis

Ears, Nose, Mouth & Throat:
- ☐ Dry Throat/Mouth
- ☐ Sinus Problems

Respiratory:
- ☐ Asthma
- ☐ Emphysema

Gastrointestinal:
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer

Genitourinary:
- ☐ Kidney Ailments
- ☐ STD: Herpes, HIV, Chlamydia

Musculoskeletal:
- ☐ Osteoarthritis
- ☐ Fibromyalgia

Integumentary:
- ☐ Eczema
- ☐ Rosacea

Psychiatric:
- ☐ Depression
- ☐ Schizophrenia

Blood/Lymphatic:
- ☐ Anemia

Other:_____

Social History

This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.

Do you use tobacco products? ☐ No Yes -- Socially ☐ Everyday ☐ Some Days ☐ Never ☐ Former Smoker ☐

Do you drink alcohol? ☐ No Yes -- Socially ☐ Occasionally ☐ 1-2 Drinks/Day ☐ Several Drinks/Day ☐

Do you use recreational or illicit drugs? ☐ No Yes -- Type/amount/duration: _____

Permissions

I give the following person(s) permission to access my medical records, to receive information on my behalf, or to speak with providers or staff at *Dr. Stephen T. Basic & Associates*.

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

Print Name Patient (or Responsible Party, if minor or special dependent)_____

Signature _____ **Date** _____