Patient History Form

Patient Name:_____ Today's Date: ____/____/____

Age:____ Sex: ____M ____F Last Eye Exam: _____ Occupation: _____

Name of Medical Doctor: _____ Last Health Physical: _____ Dr's Phone: (____)_____

Do you have any allergies to medications? Y N If yes, explain_____

LIST ALL MEDICATIONS you take (including eye drops, oral contraceptives, over the counter medicine, aspirin, vitamins and herbs)

_____

_____

Are you pregnant and/or nursing? Y N

List major injuries, surgeries or hospitalizations: _____

Eye History

Do you now wear glasses?	Y	N
Are you interested in LASIK eye surgery?	Y	N
Are you interested in Contact Lenses?	Y	N
Have you ever worn contact lenses?	Y	N
Do you now wear contact lenses?	Y	N

If yes, What type: _____

How old is your current pair? _____

Where did you acquire them? _____

My eyes are dry, itchy or irritated while wearing contacts	Y	N
My contacts are less comfortable as the day progresses	Y	N
I am interested in learning about the latest advances in contact lenses	Y	N

Do you currently, or have you ever had

Blurred vision	Y	N	Itchy Eyes	Y	N
Eye Surgery	Y	N	Lazy Eye	Y	N
Double vision	Y	N	Glaucoma	Y	N
Cataracts	Y	N	Macular Degeneration	Y	N
Eye Infections	Y	N	Eye Discharge	Y	N
Eye Injury	Y	N	Dry eyes	Y	N
Sandy/Gritty feeling	Y	N	Halos	Y	N
Glare	Y	N	Eye Pain	Y	N
see "Flashing" lights or Floating spots				Y	N

Please give details for all "yes:"

_____

_____

Family History: Please note any family history (parents, grandparents, siblings, children) for the following conditions:

Blindness	Y N who:_____	Eye Disease	Y N who:_____	High Blood Pressure	Y N who: _____
Cataracts	Y N who:_____	Heart Disease	Y N who:_____	Macular Degeneration	Y N who: _____
Glaucoma	Y N who:_____	Cancer	Y N who:_____	Retinal Detachment	Y N who: _____

Review of Systems: Do you currently or have you ever had any problems in the following area? Y N Circle all that apply

CONSTITUTIONAL
Fever, weight loss, other

INTEGUMENTARY (skin)
Herpes Zoster/Shingles, Rosacea, other

NEUROLOGICAL
Headache, Migraines, Seizures, MS, other

ENDOCRINE
Diabetes, Thyroid, other

RESPIRATORY
Asthma, Emphysema, COPD, other

CARDIOVASCULAR
Hypertension, Stroke, Heart Disease, other

GASTROINTESTINAL
Crohns, Ulcer, other

GENITOURINARY
Kidney, Bladder, other

BONES/JOINTS/MUSCLES
Rheumatoid Arthritis, Fibromyalgia, oth

HEMATOLOGIC/LYMPHATIC
Leukemia, Anemia, Bleeding, other

ALLERGIC/IMUNOLOGIC
Allergies, Autoimmune Disease, other

PSYCHIATRIC
Anxiety, Depression, other

Please explain _____

_____

Social History: *This information is kept strictly confidential, However, you may discuss this portion directly with the doctor if you prefe*

Do you drive?	Y N
Do you have visual difficulty driving?	Y N
if yes, describe _____	
Do you drink alcohol?	Y N
if yes, how much per week_____	

Do you use tobacco?	Y N
if yes, type/amount/how long _____	
Do you use street drugs?	Y N
if yes, what type _____	

Have you ever been exposed to or infected with:

Gonorrhea Y N Hepatitis Y N HIV Y N Tuberculosis Y

Patient's Signature: _____ Date: ____/____/____

Doctor's Signature: _____ Date: ____/____/__

Patient Information

Mr. / Ms. / Mrs. / Dr. _____ New Patient _____ Previous Patient

First Name : _____ Last Name: _____ MI: _____

Address _____ City _____ ST._____ Zip _____

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

D.O.B.___/___/___ Sex: M___ F___ Social Security no.: ___/___/___

Who may we thank for referring you to our office? _____ E-mail: _____

Emergency/Guardian Information

First Name : _____ Last Name: _____ Relationship: _____

Address _____ City _____ ST._____ Zip _____

Home Phone: (___)_____ Work Phone: (___)_____

Vision Insurance

Insurance Co._____

ID # _____

Group # _____

Name of Insured Person _____

Insured DOB ___/___/___

Patient relation to Insured _____

Medical Insurance

Insurance Co._____

ID # _____

Group # _____

Name of Insured Person _____

Insured DOB ___/___/___

Patient relation to Insured _____

HIPPA PRIVACY

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been presented with the Notice of Privacy Policy of C. Russo and J. Stoler, and have been offered a copy of such policy to keep for my records.

_____ (initial) I hereby acknowledge that a copy of the policy has been presented to me.

or

_____ (initial) I hereby refuse to acknowledge presentation of the policy. I understand that even though I may refuse to sign this acknowledgment, Provider may still provide treatment to me.

X_____ _____

Signature of patient/guardian Date

Insurance Agreement and Signature on File

I authorize payment of medical benefits to C. Russo and J. Stoler. I agree to pay any amount do to C. Russo and J. Stoler after my insurance company has paid or rejected my claim. I understand that all unpaid balances will be turned over to a collection agency after 30 days. Additionally, my signature below constitutes my consent for "signature on file" notation solely for the purpose of insurance filings.

X_____ _____

Signature of patient/guardian Date

OVER