Patient History Form

Today's Date:____/____/_____

Last Name:_____ First:_____ MI:____ Nickname:_____

Name of Spouse or Parent:_____ Patient's Date of Birth:____/____/_____

Address:_____ City:_____ St:_____ Zip:_____

Home Phone:(____)____-_____ Work/Cell: (____)____-_____ Employer/Occupation:_____

Email Address:_____ How did you hear about our practice? _____

Vision Insurance: _____ Medical Insurance: _____

What is the reason for today's visit? _____

Please check any of the following that YOU suffer from. Please check even if the condition is controlled with medication.

Constitution:	☐ Cancer	☐ Fatigue	☐ HIV/AIDS	☐ Other _____
Ear/Nose/Throat:	☐ Sinusitis	☐ Hearing loss	☐ Vertigo	☐ Other _____
Neurologic:	☐ Migraine	☐ Mult Sclerosis	☐ Stroke/CVA	☐ Other _____
Psychological:	☐ Depression	☐ Anxiety	☐ ADD/ADHD	☐ Other _____
Cardiovascular:	☐ **High Blood Pressure**	☐ Vascular Disease	☐ Heart Disease	☐ Other _____
Respiratory:	☐ Asthma	☐ COPD	☐ Emphysema	☐ Other _____
Gastrointestinal:	☐ Acid Reflux	☐ Ulcer	☐ Colitis	☐ Other _____
Genitourinary:	☐ Kidney Disease	☐ Prostate Disease	☐ STD	☐ Other _____
Muscular/Skeletal:	☐ Arthritis	☐ Fibromyalgia	☐ Gout	☐ Other _____
Skin/Mucous:	☐ Psoriasis	☐ Rosacea	☐ Shingles	☐ Other _____
Endocrine:	☐ **Diabetes**	☐ **Thyroid Dysfunction**	☐ Hormone dysfunction	☐ Other _____
Hematologic:	☐ **High Cholesterol**	☐ Anemia	☐ Sickle Cell	☐ Other _____
Immunologic:	☐ Rheumatoid Arth.	☐ Lupus/Sarcoid	☐ Sjogren's	☐ Other _____
	☐ Pregnant	☐ Nursing		

Are you currently taking any medications? Please list below

_____

_____

_____

Do you have any allergies? Please list medication and other allergies:

_____

Do any of the following describe YOUR EYES?

☐ Cataract	☐ Inflammatory Disorder	☐ Dry Eye
☐ Macular Degeneration	☐ Strabismus (Eye Turn)	☐ Injury
☐ Surgery	☐ Amblyopia (Poor vision in one eye since birth)	☐ Keratoconus
☐ Patching	☐ Retinal Degen/Hole/Detach	☐ Glaucoma
	☐ Nystagmus	☐ Glaucoma Suspect

Other: _____

_____

Does YOUR FAMILY suffer from any of the following?

☐ Hypertension	☐ Macular Degeneration	☐ Retinal Detachment
☐ Thyroid	☐ Cataract	☐ Blindness
☐ Diabetes	☐ Glaucoma	☐ _____
☐ Cancer	☐ Strabismus/Amblyopia	☐ _____

The following info is required to be part of your record by The Health Info Technology for Economic and Clinical Health Act (2009)

Race: ☐ Native America ☐ Asian ☐ Black/African American ☐ White ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Height: ____ft ____ in Weight: _____ lbs

Do you drink alcohol? ☐ Yes ☐ No How much: _____

Do you smoke? ☐ Never ☐ Former ☐ Currently smoke _____ packs per day

By signing below you attest to the following:

1. You have received or been offered a copy of this office's HIPAA privacy policy.
2. You give permission to Dr. Allen & Space Coast Eye Care Inc to bill insurances on your behalf.
3. You understand that you are financially responsible if your insurance company denies coverage.
4. You understand that you should not drive with dilated eyes if you do not feel comfortable.

X _____ Date: ____/____/____

(signature of patient or parent/guardian)