

Health History

Fill out this information to the best of your ability. Providing incorrect information can be *dangerous* to your health. Please inform our office when there are any changes in the medical information you provide below.

Do you wear **glasses?** Yes/No **contact lenses?** Yes/No

Have you ever had any of the following eye conditions? (Circle Yes or No)

Sandy or Gritty	Yes/No	Glaucoma	Yes/No	Loss of Peripheral Vision	Yes/No
Itchy	Yes/No	Loss of Vision	Yes/No	Double Vision	Yes/No
Burning	Yes/No	Blurred Vision	Yes/No	Dryness	Yes/No
Foreign Body Sensation	Yes/No	Fluctuating Vision	Yes/No	Mucous Discharge	Yes/No
Excess Tearing	Yes/No	Distorted Vision	Yes/No	Redness	Yes/No
Glare/Light Sensitivity	Yes/No	Tired Eyes	Yes/No	Lazy/Crossed Eye	Yes/No
Pain or Soreness	Yes/No	Drooping Eyelid	Yes/No	Retinal Detachment	Yes/No
Infection	Yes/No	Cataracts	Yes/No	Macular Degeneration	Yes/No
Flashes/Floaters	Yes/No	Eye Surgeries	Yes/No	Eye Injury	Yes/No

Medical Information

How is your general health? (*Circle appropriate*) Excellent Good Fair Poor

Medications (include Non-Prescription): _____

Allergies to medicine? Which? _____ Reactions? _____

Do you have any health issues with any of these systems? (Circle Yes or No)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary(skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Mental	Yes/No		

Explain: _____

Family History

High Blood Pressure	Yes/No	Relation: _____	Macular degeneration	Yes/No	Relation: _____
Diabetes	Yes/No	Relation: _____	Retinal Detachment	Yes/No	Relation: _____
Glaucoma	Yes/No	Relation: _____	Cataracts	Yes/No	Relation: _____

Authorization & Release

I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor and any **denied** services are my responsibility.

X _____ date: _____

SIGNATURE OF PATIENT/PARENT/OR GUARDIAN