Name:_____ **Date of Birth:**_____ **Today's Date:** _____

Referred by: _____ Name of optometrist: _____

Past Medical History: PCP: _____ Preferred Pharmacy: _____

Last Eye Exam Date: _____ Do you wear: ☐ Glasses ☐ Contacts ☐ Both ☐ None

Please mark any condition you have now or in the past: ☐ **NONE**

- ☐ Dry Eyes
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Glaucoma
- ☐ Keratoconus
- ☐ Lazy Eye/Amblyopia
- ☐ High Blood pressure
- ☐ Arrhythmia
- ☐ Heart Attack/Stents Date: _____
- ☐ Arthritis: ☐ Rheumatoid ☐ Osteoarthritis
- ☐ Asthma
- ☐ COPD
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Diabetes: Type: _____

  Most Recent Blood Sugar: _____ Date: _____

  HbA1c: _____
- ☐ LDL (High Cholesterol)
- ☐ Cancer
- ☐ Other: _____
- ☐ Other: _____

Family History: ☐ **NONE** ☐ Adopted

Please mark any conditions your family members or blood relatives have now or in the past:

- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Keratoconus
- ☐ Retinal Detachment
- ☐ Blindness
- ☐ High Blood pressure
- ☐ Heart Problems
- ☐ Arthritis: ☐ Rheumatoid ☐ Osteoarthritis
- ☐ Lung Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Diabetes: ☐ Type I ☐ Type II
- ☐ High Cholesterol (LDL)
- ☐ Cancer
- ☐ Other: _____

Have you had your: ☐ Flu vaccine: Date: _____ ☐ Pneumococcal Vaccine: Date: _____

Height: _____ Weight: _____

Review of Systems: ☐ **NONE** Circle all that apply Other:

Allergy/Immunologic:	Seasonal Allergies / Immunodeficiencies	
Cardiovascular:	Chest pain / Heart Failure / High blood pressure / Arrhythmia	
Constitutional:	Fatigue / Fever / Weight loss	
Ear/Nose/Mouth/Throat:	Deafness / Dry Mouth / Runny Nose / Sinus infection	
Endocrine:	Excessive thirst / Mood swings / High blood sugar	
Eyes:	Double vision/ Eye Pain / Vision loss / Glare / Flashing Lights Floaters / Dry Eyes / Watery Eyes / Light Sensitivity / Red Eye Itchy Eyes/ Trouble reading / Trouble Driving / Loss of Vision	
Gastrointestinal:	Constipation / Diarrhea / Hepatitis / Ulcers / Vomiting	
Genitourinary:	Blood in urine / Discharge / Genital Ulcers / Kidney stones	
Hematologic/Lymphatic:	Easy bleeding / Recurrent Infections / Easy Bruising	
Integumentary (Skin):	Eczema / Rashes / Itching / Poor wound healing / Jaundice	

Musculoskeletal:	Joint aches / Pain / Paralysis / Stiffness/ Swelling	
Neurological:	Alzheimer's / Dementia / Fainting / Headaches / Migraines / Numbness / Parkinson's / Seizures / Stroke	
Psychiatry:	Anxiety / Depression / Memory loss / Sleeping problems	
Respiratory:	Asthma / Shortness of breath / COPD / Bronchitis	

Social History:

Do you smoke? ☐ No ☐ Former Smoker ☐ Yes: Start Date:_____ Packs per Day:_____

Do you drink alcohol? ☐ No Yes: ☐ Beer ☐ Wine ☐ Spirits ☐ Former Drinker

How Often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Socially

Allergies: (to medications or food) ☐ **NONE**

_____(Reaction:_____) _____(Reaction:_____)

_____(Reaction:_____) _____(Reaction:_____)

Ocular Medications: ☐ **NONE**

_____ ☐ Both eyes ☐ Right eye ☐ Left eye How Often_____

_____ ☐ Both eyes ☐ Right eye ☐ Left eye How Often_____

Systemic Medications (including over the counter): ☐ **NONE** ☐ See Attached list

_____Dose _____ Route _____ How Often_____

_____Dose _____ Route _____ How Often_____

_____Dose _____ Route _____ How Often_____

_____Dose _____ Route _____ How Often_____

_____Dose _____ Route _____ How Often_____

_____Dose _____ Route _____ How Often_____

_____Dose _____ Route _____ How Often_____

_____Dose _____ Route _____ How Often_____

Ocular Surgeries/Procedures: (ex: LASIK, RK, Cataract, Retina, Glaucoma, Lasers, Strabismus) ☐ **NONE**

_____ ☐ Both eyes ☐ Right eye ☐ Left eye Approx Date: _____

_____ ☐ Both eyes ☐ Right eye ☐ Left eye Approx Date: _____

_____ ☐ Both eyes ☐ Right eye ☐ Left eye Approx Date: _____

Surgeries/Procedures: (ex: gallbladder, hysterectomy, appendectomy, hip replacement, etc) ☐ **NONE**

_____(Date:_____), _____(Date:_____)

_____(Date:_____), _____(Date:_____)

_____(Date:_____), _____(Date:_____)

I affirm the information I provided regarding my medical and patient information to be complete and accurate to the best of my knowledge. I understand and agree regardless of insurance status, that I am responsible for the balance on this account for any professional services rendered.

Signature: _____Printed Name:_____ Date: _____

Patient Information: *We are NOT providers for any Vision Plans*

Full Legal Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security: _____- _____- _____Employer: _____Employer Phone: _____

Home Phone: _____Cell Phone: _____

Email: _____ Preferred contact: ☐ Home ☐ Cell ☐ Email

Sex: ☐ Male ☐ Female Gender Identity: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/ Pacific Islander ☐ Latin American ☐ White
☐ Decline to Specify ☐ Other: _____

Ethnicity: ☐ African American ☐ American ☐ American Indian ☐ Chinese
☐ European American ☐ Hispanic/Latino ☐ Jewish ☐ Not Hispanic/Latino
☐ Unknown ☐ Decline to Specify

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Minor

Language: ☐ English ☐ Spanish ☐ Marshallese ☐ Sign Language ☐ Other: _____

Emergency Contact: _____ Relationship _____ Phone_____

Responsible Party/Guarantor: (if patient is less than 18 years old or covered by parents' insurance):

Name of Father _____ Date of Birth _____ Phone _____

Father's Employer _____ Phone_____

Name of Mother _____ Date of Birth _____ Phone _____

Mother's Employer _____ Phone_____

Medical Insurance_____ Policy #_____ Group # _____

Name of Policyholder _____Relationship_____

Birthdate of Policyholder _____Social Security # of Policyholder _____

Secondary Insurance Provider_____ Policy #_____ Group # _____

Birthdate of Policyholder _____Social Security # of Policyholder _____

Release of Information, Privacy Practices, and Financial Agreement

Please list those to whom we may discuss your diagnosis and treatments. I authorize Henry Eye Clinic to discuss my medical information with the following people:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I authorize Henry Eye Clinic physicians and staff to examine me (or my child), including dilation and diagnostic testing as necessary. I have been provided access to the "Notice of Privacy Policies" and I agree to the Henry Eye Clinic Financial Agreement.

Signature: _____ Date: _____