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:_____)

Patient Name: _____ Patient DOB: _____

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: _____ Preferred Name:_____

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_____

I currently reside in: ☐ Short Term Rehab ☐ Nursing Home ☐ Neither

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: I authorize Henry Eye Care to discuss my medical information with the following people

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I affirm the information I provided regarding my medical and patient information to be complete and accurate to the best of my knowledge. My signature below authorizes Henry Eye Clinic physicians and staff to examine me or the patient, 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. I understand and agree that regardless of my insurance status, that I am responsible for the balance on this account for any professional services rendered. I understand most insurance does not cover the refraction charge (which is necessary to get a glasses or contact lens prescription today or in the future) and is $42 for regular refraction and $90 for complex refraction, and I agree to pay in full at the time of services.

Signature: _____ Date: _____