PATIENT HISTORY FORM – SOUTHERN COLORADO FAMILY EYE CARE, PC

DEMOGRAPHICS Today's Date _____/_____/_____

Name _____ Birthdate _____/_____/_____ Age _____

Address _____ City/State _____ Zip _____

Cell Phone ( ) _____-_____ Home Phone ( ) _____-_____

Email _____

Name of Insurance _____Policy Holder's ID/Sponsor's SSN (for Tricare) _____

Assignment of Benefits: I authorize the release of any medical or other information necessary to process the medical claims. I authorize payment of insured medical benefits to Southern Colorado Family Eye Care, PC. This form replaces lines 12 and 13 on the HCFA 1500 form. I have reviewed the HIPAA privacy policy.

PATIENT'S or Guardian's Signature _____ (can't submit to insurance without this)

CHIEF COMPLAINT – What, **specifically**, about your eyes or vision, is the number one thing you'd like the doctor to help you with today? (What made you come in?) _____

REVIEW OF OCULAR SYSTEM - Circle any of the following that the PATIENT has/had: blurred/decreased vision, double vision, complete loss of vision, distorted vision, halos, loss of side vision, dryness, mucous discharge, redness, sandy/gritty feeling, itching, burning, watering, foreign body sensation, glare/light sensitivity, eye pain, tired eyes, crossed eyes, lazy eye, styes, flashes, floaters, glaucoma, drooping eyelids, cataracts, retinal disease, macular degeneration, eye infections, eye injury, eye herpes, eye allergies, RK, LASIK, PRK, other eye surgeries other _____

# of yrs since last eye exam ____ yrs or 1st eye exam Eye medications currently being used _____

FAMILY OCULAR HISTORY - Please note who in your immediate family (parents, grandparents, siblings, children, living or deceased) now has/has had the following **eye** conditions:

Glaucoma _____ Macular Degeneration _____ Blindness (total loss of vision) _____

Cataracts _____ Retinal Detachment _____ Crossed Eyes _____

PREVIOUS VISION CORRECTION -

Do you **currently** wear glasses? Circle one: full time, for far only, for near only, I don't wear glasses right now

How old are the **lenses** in the glasses you have with you today? _____yrs What type are these glasses? Check one below.

_____ Single Vision (it means **one single power** for just far, just near, or full time use)

_____ Lined Bifocals/Trifocals (it means **1 or 2 visible lines** with 2 or 3 powers for far, near and intermediate)

_____ Progressive Lenses (it means **no visible lines** with 3 powers for far, near and intermediate)

CONTACT LENSES -

Did you schedule to get an updated contact lens prescription today? **YES or NO If No, skip to Pg 2 If Yes, complete all below**

Do you **currently** wear contact lenses? Yes or No If not, have you worn them before? Yes or No When? _____mos/yrs ago

Are your current contacts **SOFT** (flexible) or **RIGID** (hard)? _____ If soft, what BRAND? _____

If soft, how often do you throw away each pair of lenses to begin new ones? _____

How long have you been wearing your current pair of contacts? _____ # of nights per week you sleep in your lenses____

PAGE 1 OF 2 – TURN OVER TO FILL OUT PAGE 2 OF 2

PATIENT MEDICAL HISTORY - Please circle the following conditions the PATIENT has/had and write in any others not listed.

Constitutional/General: fever, unintentional weight loss, unintentional weight gain, cancer, fatigue, _____

Ear, Nose, Mouth, Throat: seasonal allergies, hay fever, sinus congestion, chronic cough, dry mouth/throat, _____

Vascular/Cardiovascular: high blood pressure, heart pain, vascular disease, heart attack, heart surgery, _____

Respiratory: asthma, chronic bronchitis, emphysema, COPD, lung cancer, _____

Genital/Kidney/Bladder: breast cancer, kidney disease, frequent urination, gonorrhea, syphilis, PCOS, _____

Muscles/Bones/Joints: rheumatoid arthritis, muscle pain, joint pain, fibromyalgia, head or neck injury, _____

Integumentary/Skin: growths, rashes, skin cancer, acne, eczema, psoriasis, chickenpox, shingles, _____

Neurological: headaches, migraines, seizures, nerve damage, _____

Psychiatric: depression, anxiety, insomnia, ADHD, bipolar disorder, autism, PTSD, _____

Endocrine: Type 1 diabetes, Type 2 diabetes, hypothyroid, hyperthyroid, other glands, _____

Lymphatic/Hematologic: anemia, cholesterol, bleeding problems, _____

Allergic/Immunologic: lupus, HIV/AIDS, allergy shots, _____

Gastrointestinal: chronic diarrhea, chronic constipation, ulcer, acid reflux (GERD), _____

List all major injuries, surgeries, and hospitalizations you have had _____

_____

Please circle if you are **PREGNANT** or **NURSING.**

List medications you take (including Rx meds, oral contraceptives, aspirin, over-the-counter meds and home remedies). If you take several (more than 5) and have a list, we can scan it into your record. Please give the list to the front desk person.

_____

Who is your primary care physician? _____ Last Visit: _____

Do you have any **allergies to medications**? Yes or No If yes, **list the drug and the reaction**_____

_____

FAMILY MEDICAL HISTORY - Please note who in your immediate family (parents, grandparents, siblings, children, living or deceased) now has/has had the following **systemic** conditions:

Arthritis _____ High Blood Pressure_____

Cancer _____ Kidney Disease _____

Diabetes _____ Lupus _____

Heart Disease _____Thyroid _____

SOCIAL HISTORY – Occupation or Employer or if a student, what grade?_____

Smoking Status Circle one: never smoked, former smoker, light smoker (<10 cigs/day), heavy smoker (>10 cigs/day)

Alcohol? No, Yes, Occasionally **Illegal or Recreational Drugs?** Yes or No If yes, what?_____

Is there anything not listed here that you think the doctor needs to know or questions you have for the doctor?

_____1/06/17