*Welcome*

# Dawn T. Van, O.D., P.A. & Associates

## MEDICAL HISTORY

*Thank you for choosing our office for your Eyecare needs.*
*Please complete this form, and don't hesitate to ask for assistance if you have any questions. (Please Print)*

### *PATIENT INFORMATION*

Patient's Name: _____ Age: _____ Today's Date: _____

Name of Spouse: _____ If minor, Parent's Name: _____

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

Place of Employment / School: _____ Occupation: _____

Cell Phone: _____ Phone: _____ Business Phone: _____ Ext: _____

Email: _____ Social Security #: _____

Title: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other _____ Sex: ☐ Male ☐ Female Date of Birth _____

Medical Insurance: ☐ Yes ☐ No Insurance # _____ Medicare # _____ Vision Insurance: _____

### *EYE HEALTH AND MEDICAL HISTORY*

Last Eye Exam: _____ Doctor: _____ Primary Care Physician: _____

*Please Check any of the following conditions you have or have had in the past.*

| | | | | |
|---|---|---|---|---|
| ☐ Blurred Vision - Distance | ☐ Tired Eyes | ☐ Loss of Vision | ☐ Poor Color Vision | ☐ Foreign Body Sensation |
| ☐ Blurred Vision - Near | ☐ Headaches (Eye Related) | ☐ Sensitivity to Light | ☐ Sandy or Gritty Feeling | ☐ Mucous Discharge |
| ☐ Recent Chronic Eye Infection | ☐ Floaters | ☐ Computer Eyestrain | ☐ Retinal Disease | ☐ Macular Degeneration |
| ☐ Eye Injury | ☐ Flashes of Light | ☐ Dry Eyes | ☐ Glaucoma | ☐ Distorted Vision or Halos |
| ☐ Eye Strain/Soreness | ☐ Double Vision | ☐ Itchy, Watery Eyes | ☐ Cataracts | ☐ Redness |
| ☐ Eye Surgery | ☐ Problems with Glare | ☐ Seasonal Allergies | ☐ Styes | |

List any medications you are taking: _____

List any drug allergies you have: _____

Are you pregnant / nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other _____ Are they comfortable? ☐ Yes ☐ No

### *FAMILY EYE HEALTH HISTORY*

*Please Check if your blood relatives had any of the following and their relationship to you.*

| | |
|---|---|
| ☐ Lazy Eye . . . . . Relationship _____ | ☐ Glaucoma . . . . . Relationship _____ |
| ☐ Macular Degeneration. . . Relationship _____ | ☐ Cataracts. . . . . Relationship _____ |
| ☐ Retinal Detachment. . . . Relationship _____ | ☐ Diabetes . . . . . Relationship _____ |
| ☐ High Blood Pressure . . . . Relationship _____ | ☐ Cancer. . . . . Relationship _____ |
| ☐ Heart Disease . . . . . Relationship _____ | ☐ Kidney Disease . . . . . Relationship _____ |

*– OVER –*

## SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe: _____

Do you regularly use any of the following: Tobacco ☐ Yes ☐ No / Alcohol ☐ Yes ☐ No / Illegal Drugs ☐ Yes ☐ No

Have you been exposed to: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ MRSA

## MEDICAL REVIEW OF SYSTEMS

Do you currently have, or have you ever had any problems in the following areas?

***Allergic / Immunological***

| | | |
|---|---|---|
| Recurrent Infection | ☐ Yes | ☐ No |
| Hay Fever | ☐ Yes | ☐ No |
| Hives | ☐ Yes | ☐ No |

***Cardiovascular / Vascular***

| | | |
|---|---|---|
| Chest Pain | ☐ Yes | ☐ No |
| Vascular Disease / High Cholesterol | ☐ Yes | ☐ No |
| High Blood Pressure | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |

***Ear / Nose / Throat***

| | | |
|---|---|---|
| Runny Nose | ☐ Yes | ☐ No |
| Chronic Cough | ☐ Yes | ☐ No |
| Sinus Congestion | ☐ Yes | ☐ No |
| Dry Mouth | ☐ Yes | ☐ No |

***Endocrine***

| | | |
|---|---|---|
| Excess Thirst | ☐ Yes | ☐ No |
| Fatigue | ☐ Yes | ☐ No |
| Weight Change | ☐ Yes | ☐ No |
| Fainting / Nervousness | ☐ Yes | ☐ No |

***Gastrointestinal***

| | | |
|---|---|---|
| Constipation | ☐ Yes | ☐ No |
| Diarrhea | ☐ Yes | ☐ No |

***Lymphatic / Hematomic***

| | | |
|---|---|---|
| Anemia | ☐ Yes | ☐ No |
| Bleeding Problems | ☐ Yes | ☐ No |

***Genitourinary***

| | | |
|---|---|---|
| Urinary Frequency | ☐ Yes | ☐ No |
| Urinary Discomfort | ☐ Yes | ☐ No |
| Kidney Problems | ☐ Yes | ☐ No |

***Muscles / Bones / Joints***

| | | |
|---|---|---|
| Arthritis | ☐ Yes | ☐ No |
| Muscle Tenderness | ☐ Yes | ☐ No |
| Joint Pain | ☐ Yes | ☐ No |

***Neurological***

| | | |
|---|---|---|
| Headaches | ☐ Yes | ☐ No |
| Confusion / Dizziness | ☐ Yes | ☐ No |
| Seizures | ☐ Yes | ☐ No |

***Psychiatric***

| | | |
|---|---|---|
| Disorientation | ☐ Yes | ☐ No |
| Anxiety | ☐ Yes | ☐ No |
| Depression | ☐ Yes | ☐ No |

***Respiratory***

| | | |
|---|---|---|
| Asthma | ☐ Yes | ☐ No |
| Breathing Difficulty | ☐ Yes | ☐ No |
| Shortness of Breath | ☐ Yes | ☐ No |

***Skin***

| | | |
|---|---|---|
| Recurrent Dermatitis | ☐ Yes | ☐ No |
| Eczema or Rosacea | ☐ Yes | ☐ No |
| Itching / Rash | ☐ Yes | ☐ No |

## CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

We have a comprehensive Notice of Privacy Practices that describes the use and disclosure of your health information. We will not disclose your information for purposes other than for treatment including care and services provided here, and also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another healthcare professional. Similarly, we may disclose your health information for purposes of payment including our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submissions of claims to third party payers or insurers for claims review and determination of benefits and payment; among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change.

I, undersigned, have been offered a copy of the Notice of Privacy Practices and have been provided an opportunity to review it. I also understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all necessary information for treatment and to secure payment of benefits, I authorize the use of this signature on all insurance submissions if necessary.

*Doctor's Signature:* _____ *Date:* _____

*Patient / Parent Signature:* _____ *Date:* _____