



CONTACT INFORMATION

Last Name: _____ First Name: _____ MI: ___ Sex: M F
Today's Date: _____ DOB: _____ SSN: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-Mail Address: _____ Contact Preference: Home Ph. Cell Ph. Work Ph. E-Mail
Marital Status: _____ Occupation: _____ Employer: _____
Emergency Contact: _____ Phone: _____

BACKGROUND INFORMATION

Primary language spoken if not English: _____

Race:
 Asian
 Black or African American
 Native Hawaiian or other Pacific Islander
 White
 Other Race
 Decline to answer

Ethnicity:
 Not Hispanic or Latino
 Hispanic or Latino
 Unknown
 Decline to Answer

Special Needs:
 Hearing Impaired
 Translator
 Wheelchair
 N/ A

Mother's Maiden Name: _____ Mother's Birth State: _____

HEALTH HISTORY

Date of last eye exam: _____

Do you wear glasses? Yes No
 All the time
 Occasionally
 Reading
 Driving
 TV
 Other: _____

Do you wear contact lenses? Yes No
Brand: _____
Solution: _____

Do you have or have you been treated for any of the following conditions?

Blood Shot eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Halos or Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Injuries	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Light Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Night Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is there anything else that you would like the doctor to know? If so, please explain in as much detail as possible:

HEALTH HISTORY CONTINUED

Do you have any allergies? Yes No If so...

Allergy: _____ Reaction: Hives Rash Anaphylactic Shock Other: _____ Severity: Mild Moderate Severe Onset: Adult Childhood Spring Fall Seasonal

Allergy: _____ Reaction: Hives Rash Anaphylactic Shock Other: _____ Severity: Mild Moderate Severe Onset: Adult Childhood Spring Fall Seasonal

Are you currently taking any medications? Yes No If so...

Name: _____ Dose: _____ Date Started: _____
 Name: _____ Dose: _____ Date Started: _____
 Name: _____ Dose: _____ Date Started: _____
 Name: _____ Dose: _____ Date Started: _____

Do you have any medical alerts? Yes No If so, what are they? _____

Have you ever had an eye surgery? Yes No If so...

Procedure: _____ Eye: _____ Date: _____ Surgeon: _____
 Any complications: _____
 Procedure: _____ Eye: _____ Date: _____ Surgeon: _____
 Any complications: _____

Do you work on a computer? Yes No If so, how many hours per day? _____

Please check Yes or No to indicate if you or a family member has had any of the following:

	Yourself		Eye		Family Member		Relationship to Patient
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	L	R B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	L	R B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
ARMED	<input type="checkbox"/> Yes	<input type="checkbox"/> No	L	R B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Eye Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	L	R B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Retinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	L	R B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Other Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	L	R B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	L	R B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Strabismus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	L	R B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Amblyopia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	L	R B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	L	R B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	L	R B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

If other, please explain:

HEALTH HISTORY CONTINUED

Do you have or have you been treated for any of the following conditions? Please check all that apply.

Cardiovascular:

- N/A
- Angina
- Arrhythmia
- Bypass Graph
- Bypass Surgery
- Coronary Artery Disease
- Heart Disease
- High Blood Pressure
- High Cholesterol
- HTN Controlled
- HTN Uncontrolled
- MI
- Mitral Valve Prolapse
- Pacemaker
- Stroke
- Valve Replacement
- Other: _____

Ear, Nose, Throat, Mouth:

- N/A
- Chronic Sinusitis
- Chronic Strep Infections
- Deaf
- Deafness Right Ear
- Deafness Left Ear
- Hearing Aid Right Ear
- Hearing Aid Left Ear
- Hearing Aid Bilateral
- Partial Hearing Loss Right Ear
- Partial Hearing Loss Left Ear
- Partial Hearing Loss Both Ears
- Otitis Media
- Tracheostomy
- Tonsilectomy
- Other: _____

Respiratory:

- N/A
- Asthma
- COPD
- Chronic Bronchitis
- Collapsed Lung Right
- Collapsed Lung Left
- Emphysema
- Lung Cancer
- Sarcoid
- T.B.
- Chronic Cough
- Other: _____

Gastrointestinal:

- N/A
- Bowel Cancer
- Constipation
- Diverticulitis
- Esophagus
- Gall Bladder Disease
- Gastric Reflux
- Hepatitis Type A
- Hepatitis Type B
- Hepatitis Type C
- Hernia
- Pancreatitis
- Stomach Cancer
- Ulcers
- GERD
- Other: _____

Musculoskeletal:

- N/A
- Arthritis
- Bone Cancer
- Cerebral Palsy
- Gout
- Joint Pain
- Multiple Sclerosis
- Muscle Pain
- Muscular Dystrophy
- Rheumatoid Arthritis
- Other: _____

Hematologic/ Lymphatic:

- N/A
- Blood Disorders
- Hemophilia
- Leukemia
- Lyme Disease
- Lymphoma
- Other: _____

Neurological:

- N/A
- Bell's Palsy
- Cranial Nerve Palsy
- Epilepsy
- Migraines
- Seizures
- Stroke
- TIA
- Other: _____

Genitourinary:

- N/A
- Bladder Infections
- Bladder Repair
- Bladder Spasms
- Dialysis
- Endometriosis
- Kidney Failure
- Kidney Infections
- Kidney Stones
- Kidney Transplant
- Ovarian Cysts
- Ovarian Cancer
- Prostate Cancer
- Renal Stricture
- Renal Cancer
- Testicular Cancer
- Uterine Fibroids
- Uterine Cancer
- Vulvular Cancer
- Frequent Urination
- Recurrent Urinary Tract Infections
- Other: _____

Integumentary:

- N/A
- Eczema
- Skin Cancer
- Skin Rash
- Basal Cell Carcinoma
- Other: _____

Endocrine:

- N/A
- Adrenal Gland Disorders
- Diabetes
- Hypoglycemia
- Hyperadrenal Gland
- Hypoadrenal Gland
- Hyperthyroidism
- Hypothyroidism
- Other: _____

Allergic/ Immunologic:

- N/A
- Aids
- Allergy Shots
- Immune Disorder
- Lupus
- Seasonal Allergies
- Other: _____

SOCIAL HISTORY

Please check all that apply:

Alcohol:

Beer:

- 3 or less per week
- 4 or more per week
- None

Wine:

- 3 or less per week
- 4 or more per week
- None

Liquor:

- 3 or less per week
- 4 or more per week
- None

Tobacco:

- Chewing Tobacco
- Cigarettes, less than 1 PPD
- Cigarettes, 2-3 PPD

- Cigars, occasional
- Cigars, 3 or more per week
- Pipe

Tobacco Status:

- Current Everyday Smoker
- Current Someday Smoker
- Former Smoker
- Never Smoker

Insurance

Policy Holder: _____
 Relationship: Self Spouse Child Other
 Insurance Company: _____
 ID#: _____ Group #: _____
 Is Patient covered by additional insurance? If so, what is it?

Acknowledgement of Notice of Privacy Practices

I acknowledge I have been offered a copy of the Privacy Practice for Chesterfield EyeWorks. I understand the content of the notice of Privacy Practice. I give Chesterfield EyeWorks permission to leave a message on my answering machine or talk with the individuals I have listed regarding appointments, insurance or billing questions, or reports, if I am not available. I consent to primary eye care, optical services, and medications prescribed by Chesterfield EyeWorks.

Assignment and Release

I hereby certify that I, and/ or my dependent(s) have insurance and assign directly to Chesterfield EyeWorks all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Chesterfield EyeWorks may use my health care information and may disclose such information to the above named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end two years from the date signed below.

 Signature of Patient, Parent, Guardian or Personal Rep.

 Please Print name of Parent, Guardian or Personal Rep.

Date: _____ Relationship: _____

 Signature of Patient or Personal Representative
 Date: _____

Who may we leave a message with or allow to pick up glasses, contact lenses, eye drops, reports, etc.

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who may we thank for referring you?
