Today's Date ________________

Medical History Record

For faster service, please complete the following form prior to arriving at our office.

FIRST NAME: ____________________ M.I. ______ LAST NAME: ____________________

Address ____________________ City ____________________ State ________ Zip Code ________

D.O.B. ____________________ Sex: M ☐ F ☐ Email ____________________

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

Employer ____________________ Occupation ____________________

Emergency Contact ____________________ Phone Number ____________________

Date of Last Eye Exam ____________________ Name of Previous Eye Doctor ____________________

Name of General Physician ____________________ Physician's phone number ____________________

Please check YES or NO

Are you prone to fainting? ☐ Yes ☐ No

Are you sensitive to dilation drops? ☐ Yes ☐ No

Are you pregnant or planning? ☐ Yes ☐ No

Are you taking blood thinners? ☐ Yes ☐ No

Do you have any of the following? If YES please check box.

☐ Dry Eyes ☐ Eye Surgeries ☐ Wear Glasses

☐ Blurred Vision ☐ Eye Injuries ☐ Wear Contacts

Any eye problems at this time? Please explain ____________________

Are you interested in laser vision correction? ☐ Yes ☐ No

Are you interested in glasses, contact lenses, or both? ☐ Glasses ☐ Contacts ☐ Both

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature ____________________ Date ____________________

Name ____ Date ___________________________

Current and Past Medical History

(Please check all that apply and indicate when diagnosed)

- ☐ Anxiety
- ☐ Arthritis: ☐ Osteoarthritis ☐ Rheumatoid arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Cancer (Type: ___________________________)
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (High Cholesterol)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other:

  ____
- ☐ None

Past Surgical History

(Please check all that apply)

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast
- ☐ Cancer
- ☐ Colon
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart
- ☐ Joint Replacement
- ☐ Kidney
- ☐ Liver
- ☐ None
- ☐ Other:

  Please explain:

  ____
  ____
  ____
  ____
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  ____
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  ____
  ____

Ocular History

(Please check all that apply)

- ☐ Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Cataract
- ☐ Contact Lenses
- ☐ Corneal Dystrophy
- ☐ Diabetic Retinopathy
- ☐ Dry Eyes
- ☐ Glasses
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Macular ERM
- ☐ Narrow Angles
- ☐ Ocular Hypertension
- ☐ Opthalmic Migraine
- ☐ Pseudoexfoliation
- ☐ Retinal Tear
- ☐ Strabismus
- ☐ PVD
- ☐ Vitreous Floaters
- ☐ Other:

  ____
- ☐ None

Name ______________________________ Date ______________________________

Ocular Surgery (Please check all that apply)

- ☐ Blepharoplasty (Eyelid)
- ☐ Cataract Surgery
- ☐ Corneal Transplant
- ☐ DSAEK
- ☐ Eye Muscle Surgery
- ☐ Intravitreal Injections
- ☐ Lasik
- ☐ LPI
- ☐ LTP
- ☐ PRK
- ☐ Ptosis Repair
- ☐ Punctal Plugs
- ☐ Strabismus Surgery
- ☐ Retinal Laser
- ☐ Trabeculectomy
- ☐ Tube Shunt
- ☐ YAG Capsulotomy
- ☐ Other: ______________________________
- ☐ None

Family History (Please check all that apply)

- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ CVA
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Retinitis Pigmentosa
- ☐ Macular Degeneration
- ☐ Migraine
- ☐ Retinal Detachment
- ☐ Strabismus
- ☐ Other: ______________________________
- ☐ None

Medications

(Please list all current medications including over the counter medications.)

Name of Medication	Dosage

Name ______________________________ Date ______________________

Allergies **(Please check all that apply)**

- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Bee stings
- ☐ Peanuts
- ☐ Penicillin
- ☐ Sulfa
- ☐ Nickel
- ☐ Other: ______________________
- ☐ None

Social History **(Please check all that apply)**

☐ Smoking	☐ None	☐ Yes	How Much: ______________________
☐ Alcohol	☐ None	☐ Yes	How Much: ______________________
☐ Drug Use	☐ No	☐ Yes	
☐ IV Drug Use	☐ No	☐ Yes	
☐ Drives in Daytime	☐ No	☐ Yes	
☐ Drives at Night	☐ No	☐ Yes	
☐ Exercise	☐ No	☐ Yes	
☐ Caffeine Use	☐ No	☐ Yes	

Do you have any of the following? **(Please check all that apply)**

- ☐ Poor Vision
- ☐ Eye Pain
- ☐ Tearing
- ☐ Redness
- ☐ Jaw Pain
- ☐ Scalp Tenderness
- ☐ Loss of Vision
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Stuffy Nose
- ☐ Ear Ache
- ☐ Cough
- ☐ Dry Mouth
- ☐ High Blood Pressure
- ☐ Rapid Heart Beat
- ☐ Congestion
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Joint Pain
- ☐ Stiffness
- ☐ Arthritis
- ☐ Headache
- ☐ Seizure
- ☐ Stroke
- ☐ Paralysis
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Diabetes
- ☐ Thyroid Abnormalities
- ☐ Bleeding
- ☐ Anemia
- ☐ Allergies
- ☐ Hay Fever
- ☐ Hives
- ☐ Flashes (Eye)
- ☐ Floaters
- ☐ Dizziness

Professional Vision of Bel Air

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a **Patient Rights** section describing your rights under law. You have the right to review our **Notice** before signing this consent. The terms of our **Notice** may change. If we change our **Notice**, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction but if we do we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this **Consent**, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior **Consent**. The Practice provides this form to comply with the **Health Insurance Portability and Accountability Act of 1996 (HIPPA)**.

The patient understands that:

Protected heath information may be disclosed or used for treatment, payment or health care operations.

The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice and receive a paper copy of this Notice.

The Practice reserves the right to change the Notice of Privacy Policies.

The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may condition treatment upon execution of this Consent.

Please complete the list of phone numbers where we can contact you. Reasons for our needing to contact you include but are not limited to the need to confirm or change appointments, to discuss insurance or payment situations, to respond to your inquiries, etc. In using these numbers, we may talk directly with you or leave a message on an answering machine.

Phone numbers where **Professional Vision** may contact me:

(Home) ____ (Work) ____

(Cell) ____ (Other) ____

PRINT PATIENT NAME ____

Signature ____

Relationship to patient (if other than patient) ____

Date _______________________________________ Office Representative initials ________________________

I give permission for you to release my information to the following (Name, Relationship & Phone Number):

____

____