ACUITY EYE CENTER MEDICAL HISTORY RECORD

PLEASE PRINT ALL INFORMATION Today's Date: _____

Last Name: _____ First Name: _____ Nickname: _____

Address: _____ Apt#_____ Date of Birth: _____

City: _____ State:_____ Zip Code:_____ Cell Phone:_____

Gender: M F Email:_____ Can we text: Yes or No

Race: _____ Ethnicity: _____ Primary Language:_____ Home Phone:_____

Parent/Guardian (if applicable) _____ Relationship: _____

Last Eye Exam: _____ Last Medical Exam: _____ Name of Medical Dr: _____

ANY CURRENT EYE ISSUES: ___Blurred Vision ___Double Vision ___Dryness
___Flashes of light/Floaters ___Loss of Vision ___Retinal Detachment ___Eye Infection or Itching

PERSONAL HEALTH HISTORY/REVIEW OF SYSTEMS

Are you pregnant and/or nursing? ___Yes ↑___No If yes, how many weeks pregnant or nursing _____
List any surgeries and when: _____

Do you currently, or have you ever been prone to any problems in the following areas:

CONSTITUTIONAL ___FEVER ___WEIGHT GAIN ___WEIGHT LOSS
CARDIOVASCULAR ___HEART TROUBLE/PAIN ___HIGH BLOOD PRESSURE ___VASCULAR DISEASE
EARS, NOSE, MOUTH ___ALLERGIES ___CHRONIC COUGH ___DRY THROAT/MOUTH
RESPIRATORY ___ASTHMA ___EMPHYSEMA
GASTROINTESTINAL ___CONSTIPATION ___DIARRHEA
GENITOURINARY ___BLADDER/KIDNEY
MUSCULOSKELETAL ___ARTHRITIS/RHEUMATOID
INTEGUMENTARY(skin) ___YES OR ___NO
NEUROLOGICAL ___HEADACHES ___MIGRAINES
PSYCHIATRIC ___YES ___NO
ENDOCRINE ___THYROID ___DIABETES (IF YES LIST YOUR LAST HEMOGLOBIN A1c _____)
HEMATOLOGIC ___BLEEDING PROBLEMS ___HEPATITIS
IMMUNOLOGIC ___AIDS/HIV ___SYPHILIS ___LUPUS ___OTHER _____

Check any of the following that you have had: ↑___Crossed eyes ↑___Lazy eye ↑___Drooping eyelid ↑___Prominent eyes ___Glaucoma ↑___Retinal disease ↑___Cataracts
___Other (please explain) _____

FAMILY HISTORY

ARTHRITIS	___YES ___NO
BLINDNESS	↑___YES ___NO
CANCER	↑___YES ___NO
CATARACT	___YES ___NO
GLAUCOMA	___YES ___NO
RETINAL DETACHMENT/DISEASE	↑___YES ___NO
MACULAR DEGENERATION	↑___YES ___NO
LUPUS	↑___YES ___NO

-OVER-

Please check YES or NO

Do you smoke? ___YES ___NO How much?_____
Do you drink alcohol? ___YES ___NO How much?_____
Do you use other substances? ___YES ___NO

Please list any medications and current dosage:

_____

_____

Any drug allergies:_____

Do you currently wear glasses? ___YES ___NO (if YES how old is your current pair?)_____
Do you currently wear contacts? ___YES ___NO (if YES what brand?)_____

Are you interested in wearing contact lenses? ___YES ___NO

If you answered YES to any conditions or have a condition not listed, please explain:

ADDITIONAL TESTS WE OFFER

WE DO RECOMMEND THE FOLLOWING BUT REQUIRE YOUR CONSENT
(PLEASE CIRCLE YES OR NO BELOW)

RETINAL PHOTOGRAPHY **YES** **NO** (FEE $49) *Most recommended for detection of eye diseases
VISUAL FIELD SCREENING **YES** **NO** (FEE $20 optional test to detect vision loss and/or eye disease)

DILATION **YES** **NO** *takes an extra 15 min and your vision will be blurry and light sensitive.

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices*, and have reviewed all information above and it is correct to the best of my knowledge.

I give Acuity Eye Center my permission to bill my insurance company using the signature on file.

I AGREE TO PAY ALL SERVICES (including any copay and deductibles) IN FULL TODAY.

Patient/Guardian Signature:_____ Date:_____ Doctor:_____