Optimal Eyecare
Precision Vision, Quality Care

PATIENT MEDICAL HISTORY

Patient Name (Last, First)					Middle Initial		Gender	
Address					Date of Birth			
City		State		Zip		Home Phone		
Email						Cell Phone		
Employer		Preferred Language				Work Phone		

Race (select one or two)		Ethnicity (select one)
❑ White ❑ Black or African American ❑ Asian	❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander	❑ Hispanic or Latino ❑ Not Hispanic or Spanish

Primary Care Physician	

Insurance Carrier **Primary Subscriber Information** **Relationship to Patient**

☐ *check if primary subscriber names & DOB are the same as above*

_____	_____	_____	_____	_____
Medical/Primary	**Insurance ID #**	Primary Subscriber Name	DOB	(self/spouse/parent/etc)
_____	_____	_____	_____	_____
Vision/Secondary	**Insurance ID #**	Primary Subscriber Name	DOB	(self/spouse/parent/etc)

If using insurance, provide the last 4 digits of the *Primary Subscriber's* Social Security Number:	

Please provide any medical insurance card(s) with your completed paperwork.

Individuals with whom we may share medical information (spouse, children, parents, caregivers, etc.)

Name	Phone Number	Relationship	Emergency Contact?
			Yes / No
			Yes / No

Notice of Privacy Practices: I acknowledge, by my signature below that I have been given the opportunity to review the Notice of Privacy Practices and I understand that I may request a copy of this notice should I so choose.

Financial Agreement: I have read and understand the Financial Agreement and agree to comply with these terms. I understand my insurance company may make payment directly to Optimal Eyecare for services and/or materials rendered. I understand Optimal Eyecare may release information about me or my dependents necessary to process any and all claims for reimbursement on my behalf.

Authorization to Treat: I authorize Optimal Eyecare, its agents, and employees, to furnish optometric care and services, including but not limited to; diagnostic tests, examinations, and other medical and/or surgical procedures which is deemed necessary in the course of my care.

_____	_____	_____
Patient Name	**Signature** of patient or legal representative	Today's Date

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Reason for Today's Visit: _____

Last Primary Care Visit		Last Eye Exam		Currently Wear Glasses?	Yes No	Currently Wear Contacts?	Yes No
Height	*feet* *inches*		*Previous SpecRx*		*ADD*	*Previous CLRx*	*Brand/BC*
Weight	*pounds*						
Smoking	Yes No Former						

Check any **symptoms** you are currently experiencing or have recently experienced:

☐

- ☐ Blurry Vision (distance and/or near)
- ☐ Burning
- ☐ Discharge
- ☐ Double vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Pain or Soreness
- ☐ Flashes of Light
- ☐ Floaters or Spots
- ☐ Glare
- ☐ Headaches
- ☐ Itching
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

Have you ever **experienced or received treatment for any of the following**? Circle all that apply.

1.	Amblyopia, crossed or lazy eye	Yes	No	6.	Glaucoma	Yes	No	Family: _____
2.	Cataracts	Yes	No	7.	Blindness/Low vision	Yes	No	Family: _____
3.	Eye infection	Yes	No	8.	Corneal disease or keratoconus	Yes	No	Family: _____
4.	Eye injury	Yes	No	9.	Macular degeneration	Yes	No	Family: _____
5.	Eye surgery	Yes	No	10.	Retinal disease or detachment	Yes	No	Family: _____

Current **Medications**: _____ ☐ none

Current **Eye Drops** (prescription & non-prescription):_____ ☐ none

Allergies to Medications: _____ ☐ none

Have you **recently experienced or received treatment for any of the following**? Circle and check all that apply.

1.	General	fever sudden weight changes night sweats chills
2.	Neurological	stroke seizures numbness headaches/migraines dementia
3.	Immunological	seasonal allergies lupus sarcoid
4.	Endocrine	diabetes high/low thyroid pituitary
5.	Ear/nose/throat	hearing loss changes in hearing sinus problems sore throat
6.	Musculoskeletal	arthritis muscle aches joint pain multiple sclerosis
7.	Respiratory	asthma tuberculosis bronchitis sleep apnea lung cancer
8.	Cardiovascular	high blood pressure high cholesterol heart disease
9.	Skin	excessive dryness rosacea skin cancer
10.	Genitourinary	pregnant or nursing pain on urination

☐ No systemic medical conditions ☐ Other condition(s) not mentioned above: _____

Our eye doctors have multiple ways to assess the health of the back of the eye. Dilation may be required at your doctor's discretion. For comprehensive/routine eye exams, **select at least one of the following:**

- ☐ I would like a dilated examination of my eyes
- ☐ I would like Optomap ultra-widefield retinal imaging of my eyes ($39 or less)
- ☐ I would like to discuss the best examination option for my eyes with the doctor

_____ _____ _____

Patient Name **Signature** of patient or legal representative Today's Date