Visionary Eye Care Health History Form

May fax completed form to (870) 972-5684 or scan and send as an attachment to optical_bevisionary@hotmail.com

Full Legal Name: _____ Date of Birth: _____/ ____/ ____

Social Security #: ____ - ___ - ____ Phone #: (H) _____ (C) _____(W) _____

Address: _____ City, State & Zip: _____

Email: _____ Primary Care Physician/Clinic: _____

Emergency Contact & Phone #: _____

Employer/School of Patient: _____Occupation: _____

Marital Status: _____ Spouse/Parent (Responsible for bill): _____

Race: _____ Ethnicity: _____ Spouse/Parent Date of Birth: _____

CURRENT Visual Symptoms: Please circle all that apply.

Headaches	Burning Eyes	Red Eyes
Migraine Headaches	Dry Eyes	Sandy / Gritty Feeling
See Flashes	Watery Eyes	Crossed Eyes
Light Sensitive	Eye Pain	Blurred Distance Vision with corrective lenses
Glare	Soreness	Blurred Close Vision with corrective lenses
Poor Night Vision	Foreign Body Feeling	See Halos
Poor Color Vision	Eye Infection	Floaters / Spots
Tired Eyes	Itchy Eyes	Loss of Vision
Eye Strain	Mucus Discharge	
Wandering Eye	Droopy Lid	

REVIEW OF SYMPTOMS – PERSONAL MEDICAL HISTORY

Constitutional

_____ Cancer
_____ Trauma/Large Volume Blood Loss
_____ Developmental Disability
_____ Fever
_____ Weight Loss
_____ Other
_____ NONE

Ear/Nose/Throat

_____ Hearing Loss
_____ Upper Respiratory Infection
_____ Other
_____ NONE

Cardiovascular

_____ Hypertension
_____ Stroke
_____ Heart Disease
_____ Vascular Disease
_____ Other
_____ NONE

Respiratory

_____ Asthma
_____ Bronchitis
_____ Emphysema
_____ COPD
_____ Other
_____ NONE

Gastrointestinal

_____ Crohn's
_____ Colitis
_____ Acid Reflux
_____ Other
_____ NONE

Genitourinary

_____ Kidney Disease
_____ Urinary Tract Infection
_____ STD – Herpetic / Chlamydia
_____ Other
_____ NONE

Musculoskeletal

_____ Osteoarthritis
_____ Fibromyalgia
_____ Muscular Dystrophy
_____ Ankylosing Spondylitis
_____ Other
_____ NONE

Dermatologic

_____ Eczema
_____ Rosacea
_____ Psoriasis
_____ Acne
_____ Other
_____ NONE

Neurological

_____ Multiple Sclerosis
_____ Epilepsy
_____ Cerebral Palsy
_____ Tumor
_____ Other
_____ NONE

Psychiatric

_____ ADHD
_____ Depression
_____ Schizophrenia
_____ OCD
_____ Other
_____ NONE

Endocrine

_____ Non-Insulin Dependent Diabetics
_____ Insulin Dependent Diabetics
_____ Thyroid Problem
_____ Hormone Dysfuncition
_____ Other
_____ NONE

Hematological

_____ Anemia
_____ Leukemia
_____ Other
_____ NONE

Immunologic

_____ AIDS or HIV
_____ Rheumatoid Arthritis
_____ Lupus
_____ Neurofibromatosis
_____ Other
_____ NONE

_____ Pregnant
_____ Nursing
_____ N / A

_____ NO DRUG ALLERGIES

List ALLERGIES and Physical Reactions

_____ Drug

_____ Environmental

List any prescription or OTC eye drops / ointments used regularly: _____

List the nature and date of any significant eye injuries: _____

List any eye surgeries you have had and the approx. dates: _____ Surgeon? _____

Do you have: Glaucoma? _____ Cataracts? _____ Macular Degeneration? _____ Retinal Problems? _____

Medications and / or drugs (including herbal) that you are taking.

Attach a detailed list if more than 6 medications. Returning patients may also receive a printout of previous medications to compare on your exam date.

1._____ 4._____
2._____ 5._____
3._____ 6._____

YOUR FAMILY HISTORY - Has anyone in your family living or deceased been diagnosed with:

Codes: GP-grandparent, F-father, M-mother, S-sister, B-brother, CH-child, A-aunt, U-uncle

Returning patients may update changes since last eye exam.

Yes / No Blindness _____
Yes / No Cataract _____
Yes / No Glaucoma _____
Yes / No Macular Degeneration _____
Yes / No Retinal Detachment _____
Yes / No Crossed Eyes _____
Yes / No Arthritis _____

Yes / No Cancer _____
Yes / No Diabetes _____
Yes / No Heart Disease _____
Yes / No High Blood Pressure _____
Yes / No Kidney Disease _____
Yes / No Lupus _____
Yes / No Thyroid Disease _____

SOCIAL HISTORY

Yes / No Do you wear eyeglasses? _____ All the time _____ For Office Work
_____ Occasionally _____ Reading Only
_____ Driving Only _____ Sunglasses Protection

Yes / No Do you wear contact lenses? _____ Soft _____ Gas Permeable
Brand: _____

Yes / No Alcohol Use _____ Occasional _____1 / day _____ 2 / 3 day _____ 4+ / day

Yes / No Tobacco Use _____ Occasional ____ 1 / 2 pack/day _____ 2+ pack / day _____ Chew

Patient Signature _____ Dr. Signature _____ ____/____/___
(Parent signature if patient is under 18 years of age)

VISIONARY EYE CARE, P.A.
Courtney Hoffman, O.D.   Matthew Hoffman, O.D.   Douglas R. Wood, O.D.
2980 Browns Lane
Jonesboro AR 72401
(870) 972-5540
(870) 972-5684 Fax

____
Print Name of Patient

BENEFICIARY AUTHORIZATION STATEMENT
INSURANCE TO BE FILED

I request that payment of authorized Medicare, Medicaid, Blue Cross / Blue Shield, and/or any other insurance benefits be made either to me or on my behalf to VISIONARY EYE CARE, P.A. for any services furnished me by these physicians/providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration, Medicaid, Blue Cross / Blue Shield, and its agents any information needed to determine these benefits or the benefits payable for related services.

____ ___________________________
Signature of Patient or Authorized Representative **Date**

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ACKNOWLEDGEMENT OF RECEIPT FOR HIPAA / WAIVER FOR NON-COVERED SERVICES

Initial Below:

________ I acknowledge that I received / was offered a copy of ***Visionary Eye Care* PA** Notice of Privacy Practices.

________ I acknowledge that my medical or vision insurance may not cover some services deemed as medical necessities. This may include, but is not limited to, refraction, glasses, contact lenses, contact lens fittings, etc. I accept financial responsibility for any non-covered services or materials.

I give permission for the following person(s) to have access to my Personal Health Information in relation to my care at Visionary Eye Care:

____ ____

____ ____

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I would like for you to use the following ways to be contacted when my glasses / contacts are in, for appointment reminders, and for appointment confirmation: (please provide the appropriate contact number / address). Permission to leave a message, by name, on any phone number on record, to notify of materials available for pick up.

Phone call:

Primary # ___________________________________ Secondary #___________________________

Text: Cell # ___________________________________ **(if texting is OK)**

Email: ____

____
Signature of Patient or Authorized Representative