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: ______________________

Spouse/Parent (Responsible for bill): ______________________________ Spouse/Parent DOB: ________________

Marital Status: ______ Race: ______ Ethnicity: ______ Who referred you to our office? ___________________________

CURRENT Visual Symptoms: Please circle all that apply.

Headaches
Migraine Headaches
See Flashes
Light Sensitive
Glare
Poor Night Vision
Poor Color Vision
Tired Eyes
Eye Strain
Wandering Eye

Burning Eyes
Dry Eyes
Watery Eyes
Eye Pain
Soreness
Foreign Body Feeling
Eye Infection
Itchy Eyes
Mucus Discharge
Droopy Lid

Red Eyes
Sandy / Gritty Feeling
Crossed Eyes
Blurred Distance Vision with corrective lenses
Blurred Close Vision with corrective lenses
See Halos
Floaters / Spots
Loss of Vision

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.____________________________________
2.____________________________________
3.____________________________________
4.____________________________________
5.____________________________________
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