NOTICE OF PRIVACY PRACTICES

We respect our legal obligation to keep private any health information that identifies you. Our policy is displayed in the office. A copy can also be provided.

My signature below acknowledges my acceptance of the Notice of Privacy Practices.

____ ____________
Signature Date

PATIENT HISTORY

PRIMARY CARE PHYSICIAN

Primary Care Physician/Clinic Name

Address of Primary Care Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam? ____
When was your last eye exam? _________________ When was your last health exam? ____________
Past Illnesses or Injuries: ____
Past Surgeries: ____
Current Medications: ____
____
Medicines that cause reactions or sensitivities: ____
Specific Allergies: ____

YOUR EYE HISTORY

Y / N	Glaucoma	Y / N	Dryness	Y / N	Strabismus (Crossed Eyes)
Y / N	Cataract	Y / N	Excess Tearing/Watering	Y / N	Blurred Vision Distance
Y / N	Macular Degeneration	Y / N	Eye Pain or Soreness	Y / N	Blurred Vision Near
Y / N	Retinal Detachment	Y / N	Foreign Body Sensation	Y / N	Distorted Vision (halos)
Y / N	Color Blindness	Y / N	Infection of Eye or Lid	Y / N	Double Vision
Y / N	Headaches	Y / N	Itching	Y / N	Floaters or Spots
Y / N	Glare/Light Sensitivity	Y / N	Mucous Discharge	Y / N	Fluctuating Vision
Y / N	Tired Eyes	Y / N	Drooping Eyelid	Y / N	Loss of Vision
Y / N	Amblyopia (Lazy Eye)	Y / N	Redness	Y / N	Loss of Side Vision
Y / N	Burning	Y / N	Sandy or Gritty Feeling		

YOUR GENERAL HEALTH CONDITION

Y / N	Fever	Y / N	Respiratory (Asthma)	Y / N	Anxiety or Depression
Y / N	Weight Loss	Y / N	Gastrointestinal	Y / N	Thyroid
Y / N	Diabetes	Y / N	Kidney	Y / N	Blood/Lymph
Y / N	Ears, Nose, Throat	Y / N	Muscles, Bones, Joints	Y / N	Allergic
Y / N	Cardiovascular (HBP, etc)	Y / N	Skin	Y / N	Are you Pregnant?
Y / N	Neurological (MS, etc.)			Y / N	Are you Nursing?

FAMILY HISTORY

Y / N	Amblyopia (Lazy Eye)	Y / N	Retinal Detachment	Y / N	High Blood Pressure
Y / N	Blindness	Y / N	Strabismus (Eye Turn)	Y / N	Kidney Disease
Y / N	Cataract(s)	Y / N	Arthritis	Y / N	Lupus
Y / N	Color Blindness	Y / N	Cancer	Y / N	Stroke
Y / N	Glaucoma	Y / N	Diabetes	Y / N	Thyroid Disease
Y / N	Macular Degeneration	Y / N	Heart Disease	Y / N	Others