Patient History for: _____Date:_____

Date of Birth:_____Age:_____Gender: M F Spouse's/Partner's Name:_____

Address:_____Home Phone: _____

City:_____State:_____Zip Code:_____

E-mail Address: _____Cell Phone _____

Employer: _____

Work Address:_____City:_____State:_____Zip Code:_____Work Phone:_____

Occupation:_____Driver's License:_____SS#:_____

Responsible Party Name:_____**Relationship to Patient**: _____

Date of Birth:_____Age:_____Gender: M F Spouse's/Partner's Name:_____

Address:_____Home Phone: _____

City:_____State:_____Zip Code:_____

E-mail Address:_____ Cell Phone _____

Employer: _____

Work Address:_____City:_____State:_____Zip Code:_____Work Phone: _____

Occupation:_____Driver's License:_____SS#:_____

(***All contact information is for office communications only and will never be distributed to an outside entity; your privacy is important to us***)

Method of Payment: ❑ Check ❑ Cash ❑ Credit Card ❑ Insurance ❑ Medicare ❑ Care Credit

Whom may we thank for referring you to us?_____

Date of your last eye examination (if not in this office):_____Do you, or have you, ever worn glasses: ❑ yes ❑ no

Do you, or have you, ever worn contact lenses: ❑ yes ❑ no – and if you currently wear contact lenses, when did you begin wearing them:

_____

Have you ever had REFRACTIVE SURGERY for the correction of nearsightedness / farsightedness / astigmatism / other? ❑ yes ❑ no

Would you like to learn more about REFRACTIVE SURGERY as an alternative to glasses or contact lenses? ❑ yes ❑ no

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This is your opportunity to tell us about your eyes and your vision. This allows us to better provide you with the support and knowledge required to meet your eye health and visual requirements. What is your primary reason for coming here today? _____

_____

Are there times when your vision doesn't seem quite right? Tell us about this:_____

_____

What are your hobbies? (Computers, reading, bicycling, tennis, golf, needlepoint, other):_ _____

Are there any situations/activities you would enjoy doing, yet avoid because of your vision? Tell us about this:_____

General Health History: <u>Check boxes individually</u>

Allergies	❑ Me	❑ Family	❑ No
Arthritis	❑ Me	❑ Family	❑ No
Asthma	❑ Me	❑ Family	❑ No
Cancer	❑ Me	❑ Family	❑ No
Diabetes	❑ Me	❑ Family	❑ No
Drug Sensitive	❑ Me	❑ Family	❑ No
Headaches	❑ Me	❑ Family	❑ No
Heart Disease	❑ Me	❑ Family	❑ No
High Blood Pressure	❑ Me	❑ Family	❑ No
High Cholesterol	❑ Me	❑ Family	❑ No
Kidney Disease	❑ Me	❑ Family	❑ No
Other Auto-Im. Dis.	❑ Me	❑ Family	❑ No
Thyroid Abnormalities	❑ Me	❑ Family	❑ No

Eye Health History: <u>Check boxes individually</u>

Allergies (Eye)	❑ Me	❑ Family	❑ No
Cataracts	❑ Me	❑ Family	❑ No
Color "Blindness"	❑ Me	❑ Family	❑ No
Dry Eye(s)	❑ Me	❑ Family	❑ No
Flashing Lights	❑ Me	❑ Family	❑ No
Spots/Floaters	❑ Me	❑ Family	❑ No
Glaucoma	❑ Me	❑ Family	❑ No
Amblyopia (Lazy Eye)	❑ Me	❑ Family	❑ No
Light Sensitivity	❑ Me	❑ Family	❑ No
Macular Degeneration	❑ Me	❑ Family	❑ No
Retinal Detach./Tear/Hole	❑ Me	❑ Family	❑ No
Turned Eye(s)	❑ Me	❑ Family	❑ No
Other Eye Conditions	❑ Me	❑ Family	❑ No

OVER ➔➔

PFSH - Do you use cigarettes/tobacco? _____Alcohol?_____Other substances? _____

Are you currently under a physician's care? ❑ yes ❑ no

If yes, for what?_____

Name of family physician: _____

Family physician's address:_____Telephone: _____

Please list any medications (prescription and/or non-prescription) you are taking (including oral contraceptives, aspirin, over-the-counter medications, vitamins, home remedies, etc.): _____

_____

_____

Please list any major surgeries and/or hospitalizations you have had: _____

_____

_____

ROS - REVIEW OF SYSTEMS / Do you have problems with any of the following:

Constitutional (e.g. weight loss/gain; night sweats; fatigue; sleep patterns; appetite)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Eyes (e.g. vision changes; headaches; eye pain; double vision; blind spots; floaters)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Ears/Nose/Mouth/Throat (e.g. runny nose; frequent nose bleeds; stuffy ears; sore throat)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Cardiovascular System (e.g. chest pain; short breath; exercise intolerance; faintness)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Respiratory System (e.g. cough; sputum; wheeze; short breath; exercise intolerance)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Gastrointestinal System (e.g. abdominal pain; indigestion; anorexia; nausea; constipation)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Genitourinary System (e.g. Irritative or obstructive symptoms; discharge; pain)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Muscular/Skeletal System (e.g. pain; stiffness; join swelling; decreased range of motion)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Integumentary System (Skin)/Breast (e.g. rashes; lesions; wounds; tumors; eczema)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Neurological System (e.g. Changes in sight, smell, taste, hearing; seizures; pins & needles)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Mental/Psychiatric System (e.g. depression; sleep patterns; anxiety; concentration)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Endocrine (Glands) System (e.g. thyroid; diabetes; adrenal; reproductive - male / female)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Blood/Lymphatic System (e.g. anemia; petechial; excessive bleeding; hemophilia)	❑ yes	❑ no	❑ prefer to discuss with the doctor
Allergic/Immunological System (e.g. difficulty breathing; anaphylaxis; lymph nodes; itch; rash)	❑ yes	❑ no	❑ prefer to discuss with the doctor

If "yes" to any of the above, please explain: _____

_____

(Females) Are you pregnant? ❑ yes ❑ no Are you nursing? ❑ yes ❑ no

If you have any problems or conditions not listed above please list here and explain:_____

_____

Payment is expected when services are rendered. A deposit is required on all lab work before ordering. We will be happy to bill your insurance company as a courtesy for reimbursement directly to you. There will be 1½% per month service charge on all outstanding balances beyond 30 days.

In addition to my understanding of the above financial policy, I hereby grant permission to Dr. Charm and/or Anaheim Hills Family Optometry to examine and/or provide optometric services to, release medical information to the appropriate insurance company or school of, or consult when necessary with other health care professionals regarding, the above named person as may be deemed necessary or advisable.

Parent or Legal Guardian Signature

Patient Signature_____Date:_____ (If Patient is under the age of 18)_____Date:_____

Dear Patient and/or Guardian:

It is very important that we have your most current medical insurance information. This is required not only for us to bill your insurance, but to avoid having billing statements sent to you directly if and when information is missing.

Date: _____

NAME of PRIMARY Medical Insurance: _____

1. Name of insured member: _____
2. Member's date of birth: _____
3. Member's employer: _____
4. How is member related to patient? (circle one) Self; Spouse; Partner; Child; Other
5. We will need to photocopy the primary insurance card (front & back)
6. We will need to photocopy the patient's photo ID (if less than 18 yrs. old, then the ID of a parent)

Name of SECONDARY Medical Insurance: _____

1. Name of insured member: _____
2. Member's date of birth: _____
3. Member's employer: _____
4. How is member related to patient? (circle one) Self; Spouse; Partner; Child; Other

Name of PRIMARY "Vision" Insurance: _____

1. Name of vision insurance member: _____
2. Member's date of birth: _____

Name of SECONDARY "Vision" Insurance: _____

1. Name of vision insurance member: _____
2. Member's date of birth: _____