MEDICAL HISTORY

First Name_____ Middle Initial____Last Name_____Date____/____/____
Birth date____/____/____ Address_____
City_____ State_____ Zip_____
Home Phone_____Cell Phone_____Work Phone_____
Social Security Number_____Marital Status_____
Email_____Occupation_____
Pharmacy and Location_____Phone Number_____
How did you hear about our office? _____
Optometrist Name or Practice_____
Primary Care Doctor_____
Medical Health Insurance Carrier_____Name of Primary Insured_____
Relation_____Birthdate____/____/____Last 4 digits of SSN of guarantor_____

Do you have any allergies to medications? **No/Yes** If yes, explain _____
_____
List all medications you take, dosages and reason: (including aspirin, over-the-counter, and home remedies)
_____
_____
_____
List all major injuries, surgeries and hospitalizations you have had: _____
_____

Have you ever received a pneumonia vaccination? **No/Yes**
Have you received a flu shot this year? **No/Yes**

Are you pregnant or nursing? **No/Yes**
Do you currently use tobacco products? **No/Yes** Circle which: Cigarettes/Cigars/Chewing Tobacco
How much/often?_____ If you quit smoking, when?_____
Do you drink alcohol? **No /Yes** If yes, how often?_____
Do you use any other recreational drug? **No/Yes**
If yes, type and how often? _____

Date of last eye exam: _____/_____/_____
Do you wear glasses? **No/Yes** If yes, how old is your current pair? _____
Do you wear contact lenses? **No/Yes** If yes, how old is your current pair?_____
Type of contact lenses: (Circle all that apply) **Hard/Soft/ RGP/Toric/ Extended Wear(Sleep In)/Daily Wear**
Brand:_____
Do you drive? **No/Yes**
Do you have difficulty driving? **No/Yes** If yes, explain: _____

Please note any family history for following **EYE** conditions and who: self, parents, siblings, or grandparents.

Blindness_____ Cataracts_____

Crossed Eyes_____ Glaucoma_____

Macular Degeneration_____ Retinal Disease_____

Light Sensitivity_____ Double Vision _____

Loss of Vision _____ Dryness/Tearing_____

Itching _____ Redness_____

Glare/Halo _____ Recurrent Eye Pain _____

Herpes Simplex/Zoster Infection_____ Flashing Lights/Floaters_____

Recurrent Eye Infection_____ Keratoconus_____

Please note any family history for following **MEDICAL** conditions and who: self, parents, or siblings.

Allergies/Hay Fever_____ Asthma _____

Anxiety _____ Arthritis (Type)_____

Auto Immune Disease _____ Keloids/Healing Issues _____

Rosacea _____ Headaches/Migraines_____

Seizures _____Kidney Disease _____

Cancer (Type) _____ Diabetes (Type) _____

High Blood Pressure _____ Thyroid Disease_____

High Cholesterol _____ Heart Disease_____

HIV/AIDS/Hepatitis_____ Sleep Apnea_____

SIGNATURE ON FILE

We will bill any applicable insurance for services rendered. Having insurance is not a substitute for payment. It is your responsibility to pay any deductible, coinsurance, or any other balances not paid by your insurance. Refraction is the process of determining your best corrected vision. It allows the doctor to determine if there are prescription changes or if problems are due to an eye disease. Refraction is performed at the discretion of the doctor. This service is **NOT** covered by Medicare or most medical insurances. **There is a $60.00 fee for a glasses or contact lens refraction. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES THAT ARE NOT COVERED BY MY INSURANCE.** I authorize the release of any medical information to the Health Care Financial Administration and its agents. I understand the information will be used to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

PATIENT RELEASE FORM

The doctors/staff at Foulkes Vision Institute may release my medical information or answer questions about my care, either verbally or in writing, to the following:

Name/Relation _____