## Patient History Form — Simon Family Eye Care, LLC

Patient legal name:______________________________Date of Birth:______________Sex: M F

Address:______________________________City:______________State:_____Zip:________

Home phone:______________Cell phone:________________Work phone:______________

Email:______________________________Occupation/grade in school:______________

## Insurance

Responsible party (if other than self): ______________________________

Vision Care Plan:______________________________Subscriber/ID#______________

Primary medical:______________________________Subscriber/ID#______________

Secondary Medical:______________________________Subscriber/ID#______________

## Review of Systems

General health: ☐ None ☐ Cancer ☐ Developmental Delays ☐ Chronic Fatigue Syndrome ☐ Other______________

Ear, Nose, Throat: ☐ None ☐ Dry Mouth ☐ Sinusitis ☐ Hearing Loss ☐ Other______________

Neurological: ☐ None ☐ Multiple Sclerosis ☐ Epilepsy ☐ Migraines ☐ Other______________

Psychiatric: ☐ None ☐ Depression ☐ Anxiety ☐ Memory Loss/Dementia ☐ Other______________

Cardiovascular: ☐ None ☐ Hypertension ☐ Stoke/CVA ☐ Congestive Heart Failure ☐ Other______________

Respiratory: ☐ None ☐ Asthma ☐ Sleep Apnea ☐ COPD ☐ Emphysema ☐ Other______________

Gastrointestinal: ☐ None ☐ Crohn's ☐ Colitis ☐ Ulcer ☐ GERD/Acid Reflux ☐ Other______________

Genitourinary: ☐ None ☐ Prostate disease/cancer ☐ Currently pregnant or nursing ☐ Other______________

Musculoskeletal: ☐ None ☐ Ankylosing Spondylitis ☐ Osteoporosis ☐ Gout ☐ Other______________

Skin: ☐ None ☐ Herpes Zoster/Shingles ☐ Rosacea ☐ Herpes Simplex ☐ Psoriasis ☐ Other______________

Endocrine: ☐ None ☐ Diabetes ☐ Thyroid Dysfunction ☐ Hormonal Dysfunction ☐ Other ______________

Hematologic/Lymphatic: ☐ None ☐ Elevated Cholesterol ☐ Clotting Disorder ☐ Sickle Cell ☐ Other______________

Immunologic/Autoimmune: ☐ None ☐ Sjogren's Syndrome ☐ Lupus ☐Rheumatoid Arthritis ☐ Other______________

## Medications

Please list all prescription and over the counter medications, vitamins, and eye drops you are currently taking.

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

## Personal Ocular History - check if you have been diagnosed with any of the following

☐ Amblyopia ☐ Retinal Detachment/Hole/Degeneration ☐ Strabismus (eye turn) ☐ Cataract ☐ Glaucoma
☐ Macular Degeneration ☐ Keratoconus ☐ None

☐Other: ______________________________________________________________

## Family History

☐ Diabetes ☐ Hypertension ☐ Cancer ☐ Thyroid ☐ None

☐ Glaucoma ☐ Macular Degeneration ☐ Cataracts ☐ Blindness

## Social History

Number of alcoholic beverages consumed in a week: ☐ Never ☐ 1-3 ☐ 4-6 ☐ 7+ ☐ Infrequent

Do you currently smoke? ☐ Yes ☐ No Have you ever smoked? ☐ Yes ☐ No

## Optomap Retinal Scan and Dilated Fundus Exam

We have 2 different ways to view the retina as part of your health evaluation today. Please choose one of the following options:

☐ I elect to have my eyes **dilated for no addition charge**. I understand that the procedure requires eye drops that will cause my pupils to enlarge, cause light sensitivity and blurred near vision that will last approximately **4-6 hours**.

☐ I elect to have the **optomap retinal scan** which takes a 200 degree digital scan of the retina. This scan is not covered by insurance and costs **$34** in addition to the normal eye exam cost. It requires no eye drops and there are **no after-effects**.

☐ I **decline both** procedures and understand that the doctor will only have **a very limited view of the retina** which may cause retinal diseases to go undetected. I understand that I am releasing Dr. Debra Simon and Simon Family Eye Care, LLC from any liability by declining these procedures.

## Acknowledgment of Receipt of Privacy Policy

I acknowledge that I have received a copy of the Notice of Privacy Practices for Simon Family Eye Care, LLC.

Signature:_______________________________________ Date:___________________

## Contact Lens Wearer Agreement

I understand that the doctor may recommend a follow up visit to finalize the fit of my contact lenses. There is no charge for these visits within 90 days of the initial visit. After 90 days but not more than 6 months from the initial visit there is an office visit fee of $30. After 6 months a complete contact lens exam will be charged. Contact lens prescriptions expire after 1 year.

Signature:_________________________________ Date:_____________________________