***Welcome!*** *We sincerely thank you for choosing our practice for your eye care needs. A thorough medical history is very important for your optimal care. This report will be reviewed periodically with you and held in strict confidence. If you have any questions, please let us know!*

*-- Dr. Michael Wazny and Staff*

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**Date:** ____________________

**Patient's Name:** ____________________ **Preferred Nickname:** ____________________ **Sex:** M F

**Address:** ____________________ **City:** ____________________ **Zip:** ____________ **Birth Date:** ____________

**Occupation:** ____________________ **SSN: (last 4 digits)** ____________________

**Which do you prefer for future communications?** ☐ Text ☐ eMail ☐ Voice Message

**Do you have *Vision Insurance*?** ☐ Yes ☐ No ***Health Insurance*?** ☐ Yes ☐ No **Are you on *Medicare*?** ☐ Yes ☐ No

**Who shall we thank for referring you?** ☐ **Friend/Family Member:** ____________________ ☐ **Insurance**

*Contact information*

**Home Phone** ____________________ ☐

**Work Phone** ____________________ ☐

**Cell Phone** ____________________ ☐

*Please!* **eMail** ____________________ ☐

**Preferred contact method (check one)**

Patient privacy is an important issue. In our office, your medical records will be held in the strictest confidence. If you need further clarification of our HIPAA policy, or a copy of the policy, please let us know.

**Please sign if you understand our policy:** ____________________

## MEDICAL HISTORY

- Do you have allergies to any medications? ☐No ☐Yes If 'yes', please explain____________________

____________________

- List medications you currently take (including oral contraceptives, aspirin, over-the-counter drugs, home remedies, vitamins):

____________________

____________________

- List all major bodily injuries, surgeries, and/or hospitalizations you have had: ____________________

____________________

____________________

- Are you pregnant or nursing? ☐No ☐Yes

- Do you wear eyeglasses? ☐No ☐Yes If yes, how old is your present pair of lenses? ____________
- Do you wear contact lenses? ☐No ☐Yes If yes, how old is your present pair of lenses? ____________

  Type of contacts: ☐Rigid ☐Soft ☐Extended Wear ☐Other

## FAMILY HISTORY

Please check any **FAMILY** history (include parents, grandparents, siblings, children; living or deceased)

| ***Disease / Condition*** | ***Relationship** (Father, Mother, Brother, Sister, Grandmother, Grandfather, etc)* |
|---|---|
| ☐ Blindness | ____________________ |
| ☐ Cataracts | ____________________ |
| ☐ Crossed Eyes | ____________________ |
| ☐ Glaucoma | ____________________ |
| ☐ Macular Degeneration | ____________________ |
| ☐ Arthritis | ____________________ |
| ☐ Cancer | ____________________ |
| ☐ Diabetes | ____________________ |
| ☐ Heart Disease | ____________________ |
| ☐ High Blood Pressure | ____________________ |
| ☐ Kidney Disease | ____________________ |
| ☐ Lupus | ____________________ |
| ☐ Thyroid Disease | ____________________ |
| Other ____________ | ____________________ |

***-- Over --***

## SOCIAL HISTORY

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor, if you prefer.*

□Yes, I prefer to discuss my Social History information directly with the doctor.

- Do you use tobacco products? □Never Smoked □Former Smoker □Current Smoker
- Do you drink alcohol? □No □Ocassional Drink □Daily Drink □______________
- Have you ever been exposed to or infected with: □Hepatitis □STD □HIV □None / Never

## REVIEW OF SYSTEMS

*Do* ***YOU*** **currently** *have any issues in the following areas?* ***Check ALL that apply.***

### *Allergies*
□ Seasonal Allergies □ Chronic Allergies

### *Cardiovascular / Vascular*
□ Heart Pain □ High Blood Pressure
□ Vascular Disease

### *Constitutional*
□ Fever, Weight Loss/Gain
□ Fatigue Syndrome
□ Cancer ________________________________

### *Endocrine*
□ Diabetes □ Thyroid / Other Gland
□ Hormone Imbalance

### *Gastrointestinal*
□ Chronic Diarrhea □ Chronic Constipation

### *Genitourinary*
□ Genitals / Kidney / Bladder

### *Head: Ear, Nose, Mouth, Throat*
□ Allergies / Hay Fever □ Sinus Congestion
□ Running Nose □ Post-Nasal Drip
□ Chronic Cough □ Dry Throat / Mouth
□ Hearing Loss

### *Hematologic / Lymphatic*
□ Anemia □ Bleeding Problems

### *Muscles / Bone / Joints*
□ Rheumatoid Arthritis □ Muscle Pain
□ Joint Pain □ Muscular Dystrophy

### *Respiratory*
□ Asthma □ Chronic Bronchitis
□ Emphysema □ Sleep Apnea
□ COPD

### *Neurological*
□ Headaches □ Migraines
□ Seizures □ Multiple Sclerosis

### *AutoImmune Disease*
□ Rheumatoid arthritis □ Lupus
□ Celiac disease □ Sjögren's syndrome
□ Multiple sclerosis □ Ankylosing spondylitis
□ Vasculitis □ Temporal arteritis

### *Integumentary*
□ Skin Condition or Disease

### *Eyes*
□ Dry Eyes □ Lazy Eye
□ Droopy Eyelids □ Glaucoma
□ Cataracts □ Crossed Eyes

### *Vision*
□ Blurred Vision □ Loss of Vision (Blind)
□ Distorted Vision / Halos □ Loss of Side (Peripheral)
□ Double Vision □ Watery Eyes
□ Mucous Discharge □ Redness
□ Sandy or Gritty Feeling □ Itching
□ Burning □ Foreign Body Sensation
□ Excess Tearing/Watering □ Glare / Light Sensitivity
□ Eye Pain or Soreness □ Chronic Infection of Eye
□ Sties or Chalazion □ Flashes / Floaters in Vision
□ Tired Eyes

***Office Use Only***

| Date Reviewed | No Changes | Changes Noted | Doctor's Initials | Date Reviewed | No Changes | Changes Noted | Doctor's Initials |
|---|---|---|---|---|---|---|---|
| | □ | □ | | | □ | □ | |
| | □ | □ | | | □ | □ | |
| | □ | □ | | | □ | □ | |
| | □ | □ | | | □ | □ | |
| | □ | □ | | | □ | □ | |
| | □ | □ | | | □ | □ | |

Thank you for filling this out! If you have a condition not listed, or if you need to further clarify, please elaborate here:

______________________________________________________
______________________________________________________
______________________________________________________
______________________________________________________
______________________________________________________
______________________________________________________

Patient's Signature: ______________________________

Date: ____________________