The information in this confidential case history form is critical to the evaluation of your vision and health.

PATIENT INFORMATION

Today's Date _____
Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Cell Phone _____
Work Phone _____
Date of Birth _____Age _____
Patient's SSN _____
Sex M F
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____

Email Address _____

What is the major purpose of this visit?

_____
_____

Date of Last Eye Exam_____
By Whom?_____

NOTICE OF PRIVACY PRACTICES/ INSURANCE INFORMATION

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my protected health information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

INSURANCE INFORMATION RELEASE

When making an insurance claim, I authorize the release or my medical information to process my third party claim. I authorize Schultz Family Eye Care to file complaints on my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information pertinent to my case to any third party adjuster or attorney involved in resolving the financial status of my account. I authorized my third party plan to pay Schultz Family Eye Care. **If my plan does not pay this claim, I agree to be responsible for the payment of these professional services.**

Sign_____Date_____

Relationship to patient (if signing on behalf of this
patient):_____

MEDICAL HISTORY

Date of Last Physical Check-up_____

MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____

_____

_____

Allergies to medications? ❑ Yes ❑ No

If so, what medications?_____

_____

Have you had any surgeries? ❑ Yes ❑ No

Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

PERSONAL AND FAMILY HEALTH

Do you or a family member have the following health problems?

	Myself	Family
Cholesterol	❑	❑
Diabetes	❑	❑
High Blood Pressure	❑	❑
Arthritis	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

FAMILY EYE HISTORY-any family member with history of the following?

Blindness ❑_____
Cataracts ❑_____
Corneal Problems ❑_____
Diabetes ❑_____
Glaucoma ❑_____
Lazy Eye ❑_____
Macular Degeneration ❑_____
Retinal Detachment ❑_____

EYE HISTORY (Check all that apply)

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing
❑ Uncomfortable glasses
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ Other eye disorders_____

PRIMARY OR FAMILY DOCTOR:

Name_____
Street _____
City _____ State _____
Zip Code _____
Phone _____

PHARMACY:

Name_____
Street _____
City _____ State _____
Zip Code _____
Phone _____