

Today's Date _____

Patient Information

Last _____

First _____ MI _____

Street _____

City _____

State _____ Zip Code _____

Home Phone _____

Work Phone _____

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Work) _____

Date of Birth _____ Age _____ Sex: M F

Email Address _____

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Secondary Medical Insurance _____

Do you participate in a flex spending account?

Yes No

How will you settle your account today?

Cash Check Credit Card

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office? _____

If not referred, how did you choose our office?

- Another Dr. Insurance List Saw Sign/Building Newspaper/Radio/TV
 Yellow Pages: Which directory? Web Page: Which Web Site? Other

Payment is required when services are rendered and deposits are required on all eyeglasses and contact lenses ordered. I hereby authorize Dr. Arlene Schwartz to release to insurance carriers any information concerning my condition and treatments. I understand that I am financially responsible for all services rendered today if I require a referral and yet elect to visit the specialist without the referral from my primary care physician. The insurance information furnished here represents a full disclosure of the Insurance/Third Party benefits to which I am entitled. I also request payment of government/medical benefits either to myself or to the Party for services rendered.

Signature _____

Date: _____

Medical History

CHIEF COMPLAINT: How can we help you today? In this space please briefly tell us any symptoms you are experiencing.
(MEDICAL INSURANCE WILL ONLY COVER A MEDICAL REASON FOR THE EXAM WILL NOT COVER ROUTINE VISION COMPLAINTS)

Y / N Are you thinking of new glasses today?
 Y / N Are you thinking of new sunglasses today?
 Y / N Are you thinking of new contact lenses today?
 Y / N Are you interested in laser vision correction?
 Y / N Do you experience eyestrain at the computer?

HISTORY OF PRESENT ILLNESS

Location	Which eye has the problem?	R ___ L ___ Both ___
Quality	Does the problem cause vision loss or blur?	Loss ___ Blur ___
Context	Did the problem occur suddenly or gradually?	Sudden ___ Gradual ___
Severity	How sever is the problem?	Mild ___ Moderate ___ Severe ___
Modifying Factors	Is it worse at any specific distance?	Distance ___ Near ___ Both ___
Duration	How long does the problem last?	Intermittent ___ Constant ___
Timing	How long has the problem been occurring	Short term ___ Long term ___
Associated symptoms	Are there associated symptoms?	No ___ Headaches ___ Nausea ___
(Previous Interventions)	Does anything help the problem?	Nothing helps ___ Nothing has been tried ___

PAST, FAMILY AND/OR SOCIAL HISTORY

Is there anything in your past history or social history which would help us care for you?

- Past History (illnesses, operations, injuries, treatments) _____
- Family History (diseases, hereditary, risk factor, glaucoma) _____
- Social History (past and current activities) _____
- Medication History (heart meds., blood pressure) _____
- **Do you use any of the following products:** Tobacco, Alcohol, Recreation drugs

REVIEW OF SYSTEMS

Circle any of the following symptoms that apply to your eyes

EYES

Blindness	Loss of vision
Distorted vision	Blurred vision
Double vision	Cataracts
Crossed eyes	Flashes or floaters
Dry eyes	Watery eyes
Red eyes	mucous discharge
Burning or itching	Sandy or gritty feeling
Eye pain or soreness	Glare/light sensitivity
Chronic eye infection	Tired eyes
Halos	Vision Therapy
Eye surgery	Eye injury
Retinal detachment	Glaucoma

Allergic/Immunologic

Hay Fever
 Medical allergies

Constitutional Symptoms

Fever
 Weight loss

Cardiovascular

Heart pain
 High blood pressure
 Vascular disease

Ears, Nose, Mouth, Throat

Allergies/Hay Fever
 Sinus problems
 Chronic cough
 Dry throat/mouth
 Chronic ear infections

Endocrine

Diabetes
 Thyroid problems
 Other glands

Gastrointestinal

Diarrhea
 Constipation
 Ulcers

Genitourinary

Kidneys
 Bladder

Hematologic/Lymphatic

Anemia
 Bleeding problems
 Swelling

Integumentray

Skin
 Breast

Musculskeletal

Arthritis
 Rheumatoid Arthritis
 Muscle Pain
 Joint pain

Neurological

Headaches
 Migraines
 Seizures

Psychiatric

Nervous disorders
 Depression
 Compulsive behavior

Respiratory

Asthma
 Shortness of breath
 Emphysema
 Lung cancer

Have you ever been exposed to or infected with:

Gonorrhea	___Yes	___No
Hepatitis	___Yes	___No
HIV	___Yes	___No
Syphilis	___Yes	___No

Name: _____

Date: _____