DAYTON OPTOMETRIC CENTER PATIENT HISTORY FORM

Patient Name_____**Date of Birth**_____

Visual History

Briefly describe the main reason for having an examination today:

_____

Do you have any symptoms related to this?

_____

Please list all eyedrops you use (prescription or over-the-counter)_____

_____

Do you wear?: ☐ Glasses ☐ Contacts ☐ Reading glasses ☐ None

Do you have prescription sunglasses? ☐ Yes ☐ No

Are you troubled by glare? ☐ Yes ☐ No

If you currently wear or have worn contact lenses, what brand are they? _____

What contact lens solutions do you use?_____

How often do you replace your contacts? _____

Are you interested in a contact lens exam today (extra fee)? ☐ Yes ☐ No

Do you have a history of any of the following:

☐Blindness	☐Glaucoma
☐Eye Turn (Strabismus)	☐Cataracts
☐Lazy Eye (Amblyopia)	☐Macular Degeneration
☐Keratoconus	☐Retinal Detachment

Are you currently experiencing any of the following?

☐Headaches	☐Eyes itch	☐Eyes feel dry
☐Blurred Vision	☐Eyes burn	☐Eyes water
☐Double Vision	☐Eyes red	☐Flashing lights
☐Halos around lights	☐Eyes tired	☐Floaters

Other eye problems, eye conditions or eye diseases:

_____

_____

Have you had any eye injuries? ☐ Yes ☐ No If yes, describe:_____

Have you had any eye surgeries? ☐ Yes ☐ No If yes, please list_____

How many hours a day do you use a computer or electronic device (including phones and games)?

☐ Less than 2 hours ☐ 2-4 hours ☐4-6 hours ☐6-8 hours ☐ more than 8 ☐ None

Describe any visual symptoms from computer use:_____

Medical History

Primary Care Physician's Name:_____ Phone:_____

Address:_____

Preferred Pharmacy_____

Address_____

List all medications you are taking (including over-the-counter and vitamins) or provide a list.

_____

_____

_____

_____ ☐ I take no medications or vitamins

Do you have any allergies to medications? ☐ Yes ☐ No If Yes, please list:_____

Height:_____ Weight:_____ Are you pregnant or nursing? ☐ Yes ☐ No

Please review and check any conditions in the following body systems. If no, please check "None"

Constitutional/General
☐None
☐Developmental Delay
☐Weight Loss
☐Fever
☐Fatigue

Ear, Nose, Mouth, Throat
☐None
☐Upper Respiratory Infection
☐Sinus

Cardiovascular/Heart
☐None
☐High Blood Pressure
☐Vascular Disease
☐Heart Disease
☐Stroke

Respiratory/Breathing
☐None
☐Asthma
☐Emphysema
☐Bronchitis
☐COPD

Endocrine
☐None
☐Thyroid Dysfunction
☐Diabetes ☐Type 1 ☐ Type 2 ☐ Gestational Diabetes ☐ Prediabetic/borderline

Stomach/Digestion
☐None
☐Reflux
☐Crohn's Disease
☐Colitis
☐Ulcer

Genitourinary
☐None
☐Urinary Tract Infection
☐Kidney Ailments
☐Prostate
☐STD

Muscles/Bones
☐None
☐Arthritis
☐Muscular Dystrophy
☐Fibromyalgia

Blood/Liver
☐None
☐Anemia
☐High Cholesterol
☐Leukemia
☐Hepatitis

Skin
☐None
☐Eczema
☐Rosacea
☐Psoriasis
☐Growths

Neurological
☐None
☐Headaches
☐Multiple Sclerosis
☐Epilepsy
☐Alzheimers/Dementia

Psychiatric
☐None
☐Depression
☐Panic Disorder
☐Schizophrenia
☐Bipolar Disorder

Allergy/Immunologic
☐None
☐Lupus
☐HIV/AIDS
☐Allergies
type_____

If Diabetic, what year were you diagnosed? _____

Is your blood sugar controlled/stable? ☐ Yes ☐ No

What was your last blood sugar reading? _____What was your last HbA1C reading? _____

For other conditions not listed above, please list on the following page

Other Medical Conditions:

_____

_____

_____

Social History

Occupation: _____

Hobbies: _____

How often do you smoke/use tobacco products?

☐Never ☐Daily (less than 10 cigarettes/day) ☐Daily (more than 10 cigarettes/day)

☐Occasionally (not daily) ☐Former Smoker

How often do you consume alcohol? ☐Never ☐Occasionally ☐Daily

Race: ☐White ☐Black or African America ☐Asian ☐American Indian or Alaska Native

☐Pacific Islander ☐Prefer not to answer

Ethnicity: Are you Hispanic/Latino? ☐Yes ☐No ☐Prefer not to answer

Preferred language: _____

Family History

Is there any history of the following in any family members? (parents, grandparents, siblings, children)

Condition	Relationship to Patient				
☐Y ☐N Blindness	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Eye Turn (Strabismus)	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Lazy Eye (Amblyopia)	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Glaucoma	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Cataracts	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Macular Degeneration	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Retinal Detachment/Disease	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Cancer	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Diabetes	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N High Blood Pressure	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Stroke	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Thyroid Disease	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child
☐Y ☐N Other Inherited Disease	☐Mother	☐Father	☐Grandparent	☐Sibling	☐Child

If yes, what disease? _____

☐ Family history is unknown/adopted

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MEDICARE AUTHORIZATION (only if you are covered by Medicare)
I request that payment of authorized Medicare benefits be made payable to me or on my behalf to Dayton Optometric Center and its providers for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I am aware that REFRACTION, which is used to prescribe glasses, is not considered a part of medical care and is not covered by Medicare.

☐ *I have read and agree with the above statement.*

PROFESSIONAL SERVICES INSURANCE RELEASE AND ASSIGNMENT OF BENEFITS

I understand that all benefits quoted to me are **not** a guarantee of payment by my insurance company and that final determination can only be made after the claim is processed. I also authorize payment of benefits directly to Dayton Optometric Center and its providers for such services as may be provided me or my dependent. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred by the above named patient, and I agree that I am financially responsible for remaining patient balances should my insurance carrier determine the services I received are not covered. I understand that accounts 90 days old are subject to collection fees and that there is a service charge on all returned checks. Please also note a $25 no show fee will be charged for any missed appointments.
I authorize the release of any medical information necessary to process insurance claims for services provided to me by providers at Dayton Optometric Center.
A photocopy of this authorization shall be considered valid.

☐ *I have read and agree with the above statement.*

NOTICE OF PRIVACY POLICY ACKNOWLEDGEMENT
In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared. I consent to Dayton Optometric Center using and disclosing my protected personal health information to carry out treatment, payment or health care operations. *A printed copy of the Notice of Privacy Practices is available to you upon request.

☐ *I have read and agree with the above statement.*
You have the right to request that we restrict disclosure of your Protected Health Information on to certain individuals involved in your care, such as family members and friends.

☐ I do not wish any information given to anyone

OR

☐ Information may be shared with only the following persons:

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Print Patient's Name: _____

_____ _____
Signature (Patient/Legal Guardian): Date