Exam Date:_____Date:_____Date:_____Date:_____Date:_____

Patient's Name:_____ Patient's DOB:_____ ☐ M ☐ F

Patient's Address:_____City/State/Zip: _____

Patient's Phone:_____ Email: _____

Sponsor's Name:_____ Sponsor's DOB:_____ ☐ M ☐ F

Sponsor's SSN/Patient's DBN: _____Sponsor's Phone: _____

Sponsor's Address (if different from patient): _____

Patient's relationship to Sponsor (circle one): Self/Spouse/Child/Other

Has the patient ever worn (circle): Glasses/Contacts/None Approximate date of last exam: _____

**Reason for visiting today:**

- ☐ Annual Examination
- ☐ Lost or broken glasses/Want new glasses
- ☐ Want contacts/Change eye color
- ☐ Blurred distance/Near vision
- ☐ Headaches/Fatigue

**Other:** _____

**Family History (include relationship):**

- ☐ **None apply**
- ☐ Glaucoma
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid
- ☐ Retinal Disorder
- ☐ Macular Degeneration
- ☐ High Blood Pressure
- ☐ Heart Disease/Stroke
- ☐ Color Deficiency

**Other:** _____

Medications the patient is taking (i.e. oral contraceptives, aspirin, over the counter medication, & home remedies):

_____

List anything the patient is allergic to: _____

List any major eye injuries or eye surgeries the patient has had: _____

I am aware the doctor may use dilating drops: Consent___ Decline___ Signature:_____

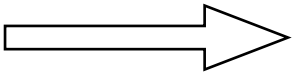
**Does the patient have health coverage under another health plan? _____**

**If you have another health insurance plan, Tricare will automatically become secondary. Payment will be due at the time of your eye exam, as your primary insurance must be billed first. <u>All insurance patients</u>: I am aware that I am responsible for any examination fee not covered by my insurance, and I acknowledge that I have been offered a copy of the privacy notice, and I authorize Family Optometric Associates, P.C. to release my medical record to Tricare/insurance company.**

**By signing below, I authorize Family Optometric Associates, P.C. to disclose my health information as needed for continuity of care by my verbal consent. This may be revoked only by a written or electronic note.**

**Patient's signature (parent, if minor): x**_____

***<u>Patients, please turn this form over and complete side 2*</u>**



*For office use only*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | DOS: | CLE/RX | Ins: | CPT: | Dx: | Verify: | Tech: |
| x: | DOS: | CLE/RX | Ins: | CPT: | Dx: | Verify: | Tech: |
| x: | DOS: | CLE/RX | Ins: | CPT: | Dx: | Verify: | Tech: |
| x: | DOS: | CLE/RX | Ins: | CPT: | Dx: | Verify: | Tech: |

What is the patient's occupation? _____

How many hours are you on a computer/phone/tablet per day? _____

How did you hear about us? _____

Are you pregnant or nursing (circle): Pregnant/Nursing/None

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**Review of Systems—** Do you currently, or have you ever had any problems in the following areas?

☐ **No current health problems**

**Eyes**
☐ **None**
☐ Loss of vision
☐ Blurred vision
☐ Dryness
☐ Mucous discharge
☐ Redness
☐ Sandy/gritty
☐ Itching/burning
☐ Chronic lid/eye infection
☐ Sty/chalazion
☐ Flashes/floaters

**Constitutional**
☐ **None**
☐ Fever
☐ Weight loss/gain

**Integumentary**
☐ **None**
☐ Skin

**Neurological**
☐ **None**
☐ Headaches
☐ Seizures

**Allergic/Immunologic**
☐ **None**

**Ears/Nose/Mouth/Throat**
☐ **None**
☐ Allergies/hay fever
☐ Sinus congestion
☐ Dry throat/mouth

**Endocrine**
☐ **None**
☐ Diabetes
☐ Thyroid/other glands

**Gastrointestinal**
☐ **None**
☐ Diarrhea
☐ Constipation

**Respiratory**
☐ **None**
☐ Asthma
☐ Emphysema

**Vascular/Cardiovascular**
☐ **None**
☐ High cholesterol
☐ High blood pressure
☐ Vascular disease

**Genitourinary**
☐ **None**
☐ Genitals/kidney/bladder

**Bones/Joint/Muscles**
☐ **None**
☐ Rheumatoid arthritis
☐ Joint/muscle pain

**Lymphatic/Hematologic**
☐ **None**
☐ Anemia
☐ Bleeding problems

**Psychiatric**
☐ **None**
☐ ADD/ADHD
☐ Autism

**Other (please list):**

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**Social History—** Required by Medicare and most insurance companies.

Does the patient…(circle): ☐ None apply

…use tobacco products? Yes/No If so, indicate type/amount/duration: _____

…drink alcohol? Yes/No If so, indicate type/amount/duration: _____

…use illegal drugs? Yes/No If so, indicate type/amount/duration: _____

Have you ever been exposed to or infected with (circle): ☐ None apply

Gonorrhea Yes/No HIV Yes/No

Hepatitis A, B, or C Yes/No Syphillis Yes/No

**Patient(parent, if minor): x**_____ **Date:** _____

Doctor: x_____ Date: _____