Antioch Eye Associates Health and History Form

Full Name: First_____MIddle_____Last_____
Nickname:_____
Gender: M / F Height:_____ Weight:_____ Date of Birth:_____
Address:Street:_____
City:_____ State:_____ Zip:_____
Home Phone:_____
Cell Phone:_____ Texting ok? Yes / No
Work Phone:_____
Email:_____
Preferred method of contact:_____
May we leave a message regarding your care on your home or cell phone? Yes / No

Referred by: Patient / Professional / None / Name:_____

Marital Status: Single / Married / Divorced / Separated / Widowed

Occupation:_____
Place of Employment:_____ Full-time / Part-time
Race: Asian / African American / White / Hispanic
Preferred Language: English / Spanish / Other_____
Hobbies:_____

INSURANCE INFORMATION: Please provide the information found on your card.

Primary Insured Social Security# (needed to authorize and submit insurance)
Name:_____SS#:_____
Relationship to insured:_____ Insured's Date of Birth:_____

Major Medical Carrier: Medicare / BCBS / Humana / Aetna / Cigna / Other_____
Member ID:_____ Plan Name:_____
Policy/Group #:_____

Secondary Insurance:_____

Vision Insurance: VSP / Eyemed / Vision Care / Cigna Vision / Humana Vision
Aetna Vision / None / Other_____
Member ID:_____

Please tell us the reason for your visit:
Exam / Glasses / Contacts / Eye Infection / Injury / LASIK consult / Other_____
Date of last eye exam:_____
Are you planning to get new glasses on this visit? Yes / No / If Necessary
How old are your current glasses?_____

Contact lens wearers: Brand:_____ Solution:_____
How often do you change your lenses?_____
Do you sleep in your contacts? Yes / No

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CURRENT OCULAR HISTORY: Please check **present** issues.

Blurred vision Distance	Blurred Vision Near	Foreign Body Sensation	Distorted Vision (halos)	Double Vision
Eye Infection	Burning	Redness	Swelling	Itching
Dry Eyes	Sandy or Gritty Feeling	Discharge watery or mucous	Light Sensitivity	Eye Pain/ Soreness
Tired Eyes	Headaches	New Floaters or Flashes	Loss of Vision	Drooping Lid
Macular Degeneration	Diabetic Retinopathy	Amblyopia (lazy eye)	Nystagmus	Color Blindness
Cataract(s)	Glaucoma	Keratoconus	None	Other_____

GENERAL HEALTH:

Date of your last physical?_____

Please provide your family doctor's name, address and contact information

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

Please provide a copy or list all current medication(s) and their reason. Include prescription, over the counter, and supplements:

Allergies to medications? Yes / No If yes, please list:_____

Environmental allergies? Yes / No If yes, please list:_____

FAMILY HISTORY: Please check all that apply.

Glaucoma	Retinal Detachment	High Cholesterol	Thyroid Disease	Color Blindness
Macular Degeneration	Amblyopia (lazy eye)	High Blood Pressure	Stroke	
Cataracts	Diabetes	Heart Disease	None	
Arthritis	Cancer	Kidney Disease	Other_____	

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SOCIAL HISTORY:
Tobacco Use: Never / Former / Current
Alcohol Use: None / Social / 1-2 daily
Narcotic Use: None / Recreational / Chemical Dependence
STD: None / Yes / HIV+
Blood Transfusion: None / Yes / HIV+

CURRENT HEALTH CONDITIONS: Please check all that apply.

Cardiovascular: Heart Disease / Elevated Cholesterol / Hypertension / Heart Attack
Stroke / Other_____

Constitutional: Anemia / Sleep Disorder / Weight loss or gain / Other_____

Ear, Nose, and Throat: Tonsillectomy / Adenoidectomy / Dental Disorder / Hearing loss
Sinus Other_____

Endocrine: Diabetes / Thyroid Disease / Other_____

Gastrointestinal: Colon Cancer / Gall Bladder / Hepatitis / Ulcer / Other_____

Genitourinary: Kidney Stones / Prostate Cancer / Other_____

Hemotologic/ Lymphatic: Anemia / Breast Cancer / Other_____

Immunologic: Lupus / Herpes Simplex or Zoster / Sjogrens / Tuberculosis / Other_____

Skin: Acne Rosacea / Dermatitis / Other_____

Musculoskeletal: Arthritis / Down's Syndrome / Osteoporosis / Other_____

Neurological: Bell's Palsy / Headaches / Multiple Sclerosis / Seizure Disorder
Other:_____

Psychiatric: ADHD / Alzheimer's / Depression / Learning Disability / Other_____

Respiratory: Asthma / Lung Disease

Pregnant or Nursing: Yes / No

Are there any other questions or concerns you have today?_____

☐ I acknowledge that I received a copy of the HIPAA privacy policy for Connie Crawford, OD,PC and Laura Cretors, OD.
My records may be released to or discussed with: Doctor / School / Family Member / All
Please list specific name(s):_____

Signature:_____ Date:_____

Relationship to patient: _____