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, James Crawford, OD, 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: ________________________