Andrew J. Hill, O.D., P.A. **Patient Information**

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date:____________ Patient Name:____ Nickname:____________________

Birthdate:__________________________ ☐ Male ☐ Female Home Phone:______________________________

Mailing Address:________________________________ City:__________________ State:______ Zip:__________

Email:________________________________ Cell Phone:______________ **Height____ft_____in Weight_______lbs**

Preference for communication: ☐ Phone (☐ Home ☐ Work ☐ Cell) ☐ Email ☐ Postal Mail

Race: ☐American Indian/Alaska Native ☐Asian ☐Black or African American ☐Hispanic ☐Native Hawaiian/Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Native Hawiian/Other Pacific Islander ☐Not Hispanic or Latino

Check appropriate box (es): ☐ Married ☐ Minor ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Student

Occupation:__________________ Employer:__________________________ Work Phone:____________________

Other Family members seen at our office:____

Whom may we thank for referring you?____

Name of person responsible for this account:__________________________ Relationship to Patient:______________

Address:____ Home Phone:__________________________

Birthdate:__________________________________ Cell Phone:__________________________________

Name of Insurance:_______________________________ Policy #_____________________________________

Card Holder's Name:____________________________________ Birthdate:_____________________________

Address:____ City:________________ State:______ Zip:____________

AUTHORIZATION & RELEASE:

It is customary to pay for service at the time incurred. We are happy to assist in filing your insurance. However you are ultimately responsible to see that payment is made by you and/or your insurance. Any deductible, co-payment and non-covered services are your responsibility. Interest will accrue on balances after 30 days due at a rate of 1.5% monthly. You may be responsible for any reasonable collection on your account, including but not limited to court costs, attorney's fees and collection agency fees.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X____ ______________________________

Signature of Patient (or parent if minor) Date

Eye History

Date of Last Eye Exam:____________________

Name of Last Eye Doctor:____

Do you currently wear: ☐ Glasses ☐ Contact Lenses (☐ Rigid ☐ Soft ☐ Extended Wear) ☐ Neither

If yes to contact lenses, what brand and power? ____

What type of contact lens cleaning solution do you use? ____________________________________

Do you have visual difficulty when reading? ☐ Yes ☐ No

Do you have visual difficulty when driving? ☐ Yes ☐ No

Are you currently using any prescription or non-prescription medication for your eye(s)? ☐ Yes ☐ No

If yes, please list:____

Have you ever had eye surgery? ☐ Yes ☐ No

If yes, please describe: ☐ Right Eye: Type of surgery:______________________ Date:____________

Type of surgery:______________________ Date:____________

☐ Left Eye Type of surgery:______________________ Date:____________

Type of surgery:______________________ Date:____________

Have you ever injured your eye? ☐ Yes ☐ No

If yes, please describe:____

Review of Systems: Please indicate any personal history below.

Condition	Yes	No
CARDIOVASCULAR SYSTEMS		
Angina	☐ Yes	☐ No
Arrhythmia	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Palpitation	☐ Yes	☐ No
Heart Disease/Attack Date________	☐ Yes	☐ No
Stroke Date________________	☐ Yes	☐ No
Hypertension (High Blood Pressure)	☐ Yes	☐ No
Elevated Cholesterol	☐ Yes	☐ No
INTEGUMENTARY		
Dry-Brittle Nails	☐ Yes	☐ No
Skin Rashes/Sores (circle)	☐ Yes	☐ No
ENDOCRINE		
Diabetes	☐ Yes	☐ No
Diabetic Retinopathy	☐ Yes	☐ No
Diabetic Suspect	☐ Yes	☐ No
Thyroid Disorder	☐ Yes	☐ No
GASTROINTESTINAL		
Acid Reflux	☐ Yes	☐ No
Cancer: Colon Liver (circle)	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Gall Bladder	☐ Yes	☐ No
Gastrointestinal Disorder	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No
Appetite Loss	☐ Yes	☐ No
Nausea/Vomiting (circle)	☐ Yes	☐ No
GENITOURINARY		
Bladder Infections	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
Prostate/Uterine Cancer	☐ Yes	☐ No
Frequent Urination	☐ Yes	☐ No
HEAD		
Dry Mouth	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
HEMATOLOGIC/LYMPHATIC		
Anemia	☐ Yes	☐ No
Breast Cancer	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No
Bruising Problems	☐ Yes	☐ No
Clotting Problems	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No

Condition	Yes	No
IMMUNOLOGIC		
HIV Positive/AIDS	☐ Yes	☐ No
Bacterial Infection	☐ Yes	☐ No
Lyme Disease	☐ Yes	☐ No
Mononucleosis	☐ Yes	☐ No
Viral Infection	☐ Yes	☐ No
CONSTITUTIONAL		
Change in skin color	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Recent weight change: gain loss	☐ Yes	☐ No
MUSCULOSKELETAL		
Arthritis	☐ Yes	☐ No
Myasthenia Gravis	☐ Yes	☐ No
Downs Syndrome	☐ Yes	☐ No
Back/Joint Pain (circle)	☐ Yes	☐ No
Muscle Pain/Weakness (circle)	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Polymyalgia	☐ Yes	☐ No
NEUROLOGICAL		
Bell's Palsy History	☐ Yes	☐ No
Brain Tumor	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No
Dyslexia	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Headache (Migraines)	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Nystagmus	☐ Yes	☐ No
Parkinson's	☐ Yes	☐ No
Seizures/Tremors (circle)	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No
PSYCHIATRIC		
Alzheimer's Disease	☐ Yes	☐ No
Anxiety Disorder	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No
Memory Loss	☐ Yes	☐ No
Psychiatric Disorder	☐ Yes	☐ No
RESPIRATORY		
Asthma	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Lung Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

CANCER (Not listed above) ☐ Yes ☐ No If yes, type____

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	☐ Yes	☐ No	Novocain or other anesthetics	☐ Yes	☐ No
Morphine, Demerol, or other narcotics	☐ Yes	☐ No	Aspirin or other pain remedies	☐ Yes	☐ No

List other drug allergies(including type of reaction)____

____

List of medications and dosage:____

Name of Primary Care Physician:____

Have you ever had any of the following eye conditions? Family history is unknown ☐ Yes

			Family History	Check here if you are currently experiencing this condition				Check here if you are currently experiencing this condition
Glaucoma	☐ Yes	☐ No	☐	☐	Halos	☐ Yes	☐ No	☐
Macular Degeneration	☐ Yes	☐ No	☐	☐	Light Sensitivity	☐ Yes	☐ No	☐
Cataracts	☐ Yes	☐ No	☐	☐	Redness	☐ Yes	☐ No	☐
Retinal tear or detachment	☐ Yes	☐ No	☐	☐	Itching	☐ Yes	☐ No	☐
Lazy eye/wandering eye	☐ Yes	☐ No	☐	☐	Burning	☐ Yes	☐ No	☐
Eye Pain	☐ Yes	☐ No		☐	Dryness	☐ Yes	☐ No	☐
Blurred Vision	☐ Yes	☐ No		☐	Sandy/Gritty Sensation	☐ Yes	☐ No	☐
Decreased Vision	☐ Yes	☐ No		☐	Foreign Body Sensation	☐ Yes	☐ No	☐
Double Vision	☐ Yes	☐ No		☐	Discharge	☐ Yes	☐ No	☐
Flashes of light in eye(s)	☐ Yes	☐ No		☐	Crusting of eyelid	☐ Yes	☐ No	☐
Floating dark spots in eye(s)	☐ Yes	☐ No		☐	Drooping eyelid	☐ Yes	☐ No	☐

Other:____________________________

Patient Social History

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of tobacco: ☐ Never ☐ Previously, but quit (when?)________ ☐ Current packs/day________

Use of illegal drugs: ☐ Never ☐ Type/frequency____________________

Excessive exposure at home or work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles ☐ Noise

LIST OF SURGERIES (Please include the date):______________________________

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X____ Date:________________

Patient / Guardian Signature