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| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  |  | | --- | --- | --- | | WELCOME TO OUR OFFICE! IT’S A PLEASURE TO SERVE YOU! PLEASE HELP US GET TO KNOW YOUR CONCERNS BY FILLING OUT THE FOLLOWING FORM: |  | NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | | --- | | Reason for Today’s Visit: | | Special Eye or Vision Problems/hobbies: | | I wear glasses for \_\_\_\_\_\_Distance \_\_\_\_\_\_Near \_\_\_\_\_\_Computer \_\_\_\_\_\_\_Sun \_\_\_\_\_\_Hobbies  Today I am interested in: Glasses Contacts |  |  | | --- | | Other concerns: | | Other questions: | | | Employer/Occupation: | | Home Address/City/State/ZIP  Cell Phone if it is OK that we contact you by phone, voice mail or text?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other Phone: work/home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Your email address if it is OK to contact you this way:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Vision Insurance Company**: Name on Card: | | | | | | | | | |
| Cardholder Name/ DOB/ SSN or member ID number/Relationship: SELF SPOUSE or PARENT (circle one) | | | | | | | | |
| **Health Insurance Company:** Name on Card: | | | | | | | | |
| Cardholder name/DOB/ Contract and Group Number/Relationship: SELF SPOUSE or PARENT (circle one) | | | | | | | | |
| Date of Last Physical/Physician’s name Pharmacy/Phone or location: | | | | | | | | |
| Last Eye Exam Date/ Doctor’s Name/ City: | | | | | | | | |
| I have read, understand and agree to the terms of the following consent forms: (Please Initial if applicable)  \_\_\_\_\_\_\_Dilation\* \_\_\_\_\_\_ HIPPA Use of Information\* to communicate with Pharmacy (download medication list  and history and send rx’s electronically), Physician(s) and Insurance companies.  \*Please see accompanying office policy regarding use of your medical information. | | | | | | | | |
| **Please check all that apply now or in past:** | **Yes** | **No** | **Additional Details:** | **Please check all that apply:** | **YES** | **NO** | **Additional details:** |
| **EYES: (please circle)** |  |  |  | **LUNGS/HEART** |  |  |  |
| Blur at distance, near or mid-range (please circle) |  |  |  | Breathing problems/asthma |  |  |  |
| Dry Eyes/ Pain in eyes |  |  |  | Enlarged Heart |  |  |  |
| Tired Eyes/ Eye Strain |  |  |  | Emphysema |  |  |  |
| Tearing/Redness/ Discharge |  |  |  | High Blood Pressure |  |  |  |
| Itching/Burning/Gritty |  |  |  | Shortness of Breath |  |  |  |
| Eyelid Swelling |  |  |  | Tuberculosis |  |  |  |
| Eye Turn/ Lazy Eye |  |  |  | Irregular Heart Beat/MVP |  |  |  |
| Past Eye Injury or Surgery |  |  |  | **SKIN** |  |  |  |
| Light Sensitivity |  |  |  | Melanoma |  |  |  |
| Floaters/ Flashes |  |  |  | Oral Acne Treatment |  |  |  |
| Double vision |  |  |  | Skin Cancer |  |  |  |
| Glaucoma (self or family) |  |  |  | Skin rash/itching |  |  |  |
| Family Eye disease or blindness: |  |  |  | Skin numbness |  |  |  |
| **NUEROLOGICAL:** |  |  |  | **GLANDS/IMMUNE:** |  |  |  |
| Anxiety/Depression |  |  |  | Neck/Back Problems |  |  |  |
| Seizures |  |  |  | Arthritis/ Allergies |  |  |  |
| Dizziness |  |  |  | Dibetes/Thyroid |  |  |  |
| Seizures/ Paralysis/ Stroke |  |  |  | Lupus/ Sarcoid |  |  |  |
| **HEAD:** |  |  |  | **URINARY:** |  |  |  |
| Dry Mouth |  |  |  | Bladder problems |  |  |  |
| Sleep Problems |  |  |  | Kidney Problems |  |  |  |
| Headaches/ Migraines |  |  |  | **GASTROINTESTINAL:** |  |  |  |
| Ear/ Hearing Problems |  |  |  | Digestive problems |  |  |  |
| Sinus Problems |  |  |  | Liver Disease |  |  |  |
| **CONSTITUTIONAL:** |  |  |  | Bowel Problems |  |  |  |
| Fever/Weight Change |  |  |  | **BLOOD:** |  |  |  |
| **REPRODUCTIVE:**  Nursing, Planning/ Pregnancy |  |  |  | Anemia/ Clot or Bleeding Problems |  |  |  |
| **FAMILY & SOCIAL HISTORY:** |  |  |  | **Please list any:** |  |  |  |
| Family History Heart Problems or Diabetes |  |  |  | Past surgeries: |  |  |  |
| Past/ Present Smoker |  |  |  | Drug allergies: |  |  |  |

PLEASE SIGN AND DATE BELOW. Forms may only be securely faxed to 205-327-1349. Thank you!

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_