PREMIER VISION - PATIENT HISTORY

Today's Date: _____ 1st Review Date: _____ 2nd Review Date: _____

Patient Legal Name: _____ Date of Birth: _____

SELF - HEALTH HISTORY

Dr. Name & Place of Last Eye Exam: _____ Date:_____

Primary Care Physician: _____ Physician's Phone: _____ Pharmacy/Location_____

IF YES, PLEASE CIRCLE ANY SYMPTOMS THAT APPLY:	YES	NO	ONSET DATE
General/Constitutional (fever, weight loss or gain, other)			
Ear/Nose/Throat (sinus, ear infection, cough, dry mouth, etc.)			
Neurological (stroke, Alzheimer's, migraines, MS, numbness, headache, etc.)			
Psychiatric (anxiety, depression, insomnia, etc.)			
Cardio (high blood pressure, heart attack, heart disease, etc.)			
Respiratory (asthma, bronchitis, emphysema, COPD, congestion, etc.)			
Gastrointestinal (Crohn's disease, GERD, stomach upset, diarrhea, constipation, etc.)			
Genital/Kidney/Bladder (kidney disease, painful or frequent urination, impotence, prostate, etc.)			
Muscular/Skelton (arthritis, back pain, joint pain, stiffness, swelling, cramps, etc.)			
Integ/Skin (cancer, rosacea, psoriasis, eczema, seborrhea, pimples, warts, growths, rash, etc.)			
Endocrine (diabetes, thyroid disorders, etc.)			
Hemo/Blood/Lymph (high cholesterol, anemia, cancer, etc.)			
Allergy/Immunologic (sneezing, swelling, redness, itching, hives, seasonal allergies, AIDS, etc.)			

EYE SYMPTOMS/ DRY EYE DISEASE QUESTIONAIRRE (Check all that apply)

_____ Dry Eyes
_____ Fluctuation in Vision
_____ Contact Lens Discomfort
_____ Light Sensitivity
_____ Tired Eyes
_____ Redness
_____ Burning
_____ Itchy
_____ Watery Eyes
_____ No Symptoms
_____ Other Symptoms

MEDICATION TABLE

Medications	Dosage	Date Begun	Date Ended	For Condition

(Continued on Back)

MEDICATION ALLERGIES

If No Medication Allergy, Check Here ☐

Medication Allergy: Description of Allergic Reaction:

_____ _____

_____ _____

Other Allergies:_____ IfAllergic to Latex, Check Here ☐

SELF - OCULAR HISTORY

	YES	NO		YES	NO
Cataract			Injury to Eye or Head		
Glaucoma			Ocular Foreign Body Removal		
Macular Degeneration			Explain: _____		
Blindness			Amblyopia (lazy eye)		
Retinal Detachment			Strabismus (eye turn)		
Eye Surgery			Eye Infections		

Explain: _____ Other: _____

FAMILY (blood relatives) HEALTH HISTORY

	YES	NO	Relationship		YES	NO	Relationship
Cataract				High Blood Pressure			
Glaucoma				Heart Problems			
Macular Degeneration				Stroke			
Blindness				Thyroid Problems			
Retinal Detachment				Cancer			
Diabetes				Arthritis			

Other: _____

SOCIAL HISTORY (Ages 13 and older)

TOBACCO USE:

☐ Current Every Day Smoker (smoked at least 100 cigarettes during lifetime & still smoke every day)

☐ Current Some Day Smoker(smoked at least 100 cigarettes during lifetime & still smoke periodically, yet consistently)

☐ Former Smoker (smoked at least 100 cigarettes during lifetime but do not currently smoke)

☐ Never Smoked (have not smoked 100 or more cigarettes during lifetime)

ALCOHOL USE:

Never ☐ Rarely ☐ Moderate ☐ Daily ☐

SUBSTANCE ABUSE:

Never ☐ Rarely ☐ Moderate ☐ Daily ☐

PREMIER VISION - PATIENT INFORMATION

PATIENT DEMOGRAPHICS

Patient Legal Name: _____ Preferred Name: _____

Mailing Address: _____ Apt.#____ City: _____ State: ____ Zip: _____

Date of Birth: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Method of Contact (please circle): Cell Phone Home Phone Work Phone

Social Security # (for insurance purposes only): _____ Marital Status: S M D W

Insurance Carrier: (Vision)_____ (Medical)_____

Insurance Subscriber:_____ Insurance Subscriber's Date of Birth _____

Subscriber's Employer: _____ Patient's Employer:_____

Race & Ethnicity: White American Indian Black Hispanic Asian Pacific Islander Other _____

Preferred Language *(please circle)*: English Spanish Other _____

Hobbies/Interests:_____

NOTICE OF PRIVACY PRACTICES / RELEASE OF INFORMATION AUTHORIZATION

I acknowledge I have been given a copy of SE Professionals, SC dba: Premier Vision Notice of Privacy Practices (updated 9/18/13), which describes in detail how SE Professionals may use and disclose my private health information.

Signature_____ Date _____
Patient (or parent if minor)

I authorize Premier Vision to identify themselves in the following methods:

- ☐ Future mailings
- ☐ When calling or texting my cell, home, or work phone
- ☐ By email
- ☐ With anyone who answers my phone or voicemail when leaving appointment information

I authorize Premier Vision to release my personal health information to the following person(s) by telephone, writing, or in person.

Name_____ Relationship_____

Name_____ Relationship_____

Your signature will remain in effect until otherwise revoked by you in writing.

Signature_____ Date _____
Patient (or parent if minor)

REFERRAL SOURCE (please check any that apply)

_____ Insurance _____ Phone Book _____ Internet Directory Listing _____ Internet Ad

_____ Return Patient _____ Friend or Family _____ Name of Internet Site