EYE BOUTIQUE
A VIEW FOR LIFE.

PATIENT HEALTH HISTORY

SSN4: _____

Date: _____

First Name: _____ Last Name: _____ DOB: _____ Email: _____

Address: _____ City:_____ State: _____ Zip: _____ Mobile Phone :_____

Primary Care Physician: _____ Occupation: _____ Gender:

Due to current Federal Medical Guidelines, we are required to obtain the following information

Preferred Language: **Preferred Communication Preference**:

Race:

Ethnicity:

What is the main reason for your visit today? _____ **Do you wear?** **Are you interested in contacts?**

Medical/Family History

Please list current medications:_____

_____

List any allergic reactions to **medications or eye drops**: _____

_____

Women – Are you pregnant?

Please indicate if any of the conditions apply:

Disease/Condition	Yourself Yes	Yourself No		Family Member Yes	Family Member No	Relationship (Blood Relatives Only)
Cataract	☐	☐	Blindness	☐	☐	_____
Eye Turn	☐	☐	Eye Turn	☐	☐	_____
Glaucoma	☐	☐	Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	Retinal Detachment	☐	☐	_____
Eye Surgery	☐	☐				
Eye Injury	☐	☐				

Other:_____

Are you diabetic? If so, what year were you diagnosed? _____ What was your blood sugar today? _____

What is your most current HbA1C? _____

Review of Systems Please indicate below (check) if you have any of the following conditions:

Social Tobacco Use: ☐Non-prescription drugs ☐Alcohol Consumption

Allergic/Immunologic
- ☐Lupus (SLE)
- ☐Rheumatoid Arthritis
- ☐Environmental Allergies
- ☐Seasonal Allergies
- ☐Other (i.e., Latex)

Ear, Nose and Throat
- ☐Sinusitis
- ☐Upper Respiratory Tract Infection
- ☐Other

Gastrointestinal
- ☐Crohn's Disease
- ☐Colitis
- ☐Acid Reflux/Ulcer
- ☐Other

Skin/Integumentary
- ☐Eczema
- ☐Rosacea
- ☐Psoriasis
- ☐Other

Psychiatric
- ☐Depression
- ☐Bi-Polar
- ☐Schizophrenia
- ☐Other

Cardiovascular
- ☐High Blood Pressure
- ☐Heart Disease
- ☐Stroke
- ☐Vascular Disease
- ☐High Blood Cholesterol

Endocrine/Glands
- ☐Diabetes
- ☐Hormone Dysfunction
- ☐Thyroid Dysfunction
- ☐Other

Respiratory
- ☐Asthma
- ☐Bronchitis
- ☐Emphysema
- ☐Other

Muscle/Skeletal
- ☐Arthritis
- ☐Fibromyalgia
- ☐Ankylosing Spondylitis
- ☐Other

Genital/Urinary
- ☐Urinary Tract Infection
- ☐HIV Positive
- ☐Herpes/Chlamydia
- Other

Hematologic/Lymphatic
- ☐Anemia
- ☐Leukemia
- ☐Bleeding Disorder
- ☐Other

Neurological
- ☐Multiple Sclerosis
- ☐Epilepsy
- ☐Tremors
- ☐Other

General Health
- ☐Weight loss/gain
- ☐Fever
- ☐Fatigue
- ☐Trauma

Lifestyle Information: To help us assist you with your eye care needs, please check all that apply:

☐Boating/Fishing ☐Computer use (give % of time each day _____) ☐Shooting ☐Golfing ☐Motorcycling ☐Bicycling
☐Participate in Sports ☐Swimming ☐Driving ☐Hunting ☐Close-up work ☐Woodworking ☐Use of Power Tools
☐Intermediate Work ☐Gardening ☐Reading ☐Hiking ☐Other:_____

Insurance Information: Are you covered by vision coverage? If yes, please list: _____

SSN/Insurance #: _____ Do you have secondary vision coverage? _____

We will make every effort to check your eligibility with your insurance carrier. Because of the ever-changing information with insurance companies and/or circumstances beyond our control, WE CANNOT GUARANTEE THAT YOUR VISION BENEFITS WILL ALWAYS COVER PART OR ALL OF YOUR PURCHASES FROM US. You will be responsible for any unpaid balance. If you have any concerns regarding your insurance benefits and eligibility, we urge you to contact your insurance carrier before you order products or services from us.

Servicing and collections

If we need to contact you to service your account or to collect amounts you owe, you authorize us (and our affiliates, agents and contractors) to contact you at any number you provide, from which you call us, or at which we believe we can reach you. We may contact you in any way, such as calling, texting or emailing. We may contact you using an automated dialer or pre-recorded messages. We may contact you on a mobile, wireless or similar device, even if you are charged for it. If your account goes into collections, you will be required to pay the full balance of your account and an additional $36 collection fee. We may communicate with you via email, electronic or print newsletter, electronic or print surveys, social media platforms (e.g., Facebook, Instagram, Twitter, YouTube, Pinterest, Linkedin, Pinterest) or by postcard.

Please sign to acknowledge this form is current and that you received a copy of our Notice of Privacy Practices.

Patient's Signature or legal guardian : _____ Date: _____

Initials: _____

FOR OFFICE USE:

Eyeglasses 1: Date :_____

OD_____ Add: _____ Type: _____

OS _____ Add: _____ Material: _____

☐ Transitions ☐ Polarized ☐ Anti-Reflective ☐ Teflon AR ☐ Tint

Eyeglasses 2: Date: _____

OD_____ Add: _____ Type: _____

OS _____ Add: _____ Material: _____

☐ Transitions ☐ Polarized ☐ Anti-Reflective ☐ Teflon AR ☐ Tint

Contact Lenses:

Brand: _____ OD_____

BC: _____ OS _____

New Contact lens or trials

Brand: _____ OD_____

BC: _____ OS _____

Based on the patient's lifestyle, prescription and ocular health needs, what products do you recommend? (completed by Optometrist)

☐ Teflon Coating ☐ Prescription Sunglasses ☐ Back-up pair of eyeglasses for contact lens wearers ☐ Progressive No-Lines Polarized

☐ UV protection ☐ Multiple Pair

Additional Notes:

_____

_____

_____

_____