

**Please answer the following questions about your medical status and history:**

1. Have you ever been treated for any medical conditions? (e.g. diabetes, high blood pressure, arthritis etc.)  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please explain: \_\_\_\_\_
2. Have you ever had any eye disease? (e.g. glaucoma, cataract, wandering or “lazy” eye, retinal detachment)  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please explain: \_\_\_\_\_
3. Have you ever had any surgery?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please provide date and reason: \_\_\_\_\_
4. Have you ever been hospitalized?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please provide date and reason: \_\_\_\_\_
5. Do you take any medications?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please provide list: \_\_\_\_\_
6. Do you have any drug or food allergies?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please list: \_\_\_\_\_
7. Do you wear glasses? Yes No
8. Do you wear contact lenses? Yes No
9. Do you have difficulty seeing when driving? Yes No
10. Do you have a problem with night vision? Yes No
11. When was your last eye exam? \_\_\_\_\_ By whom? \_\_\_\_\_

**REVIEW OF SYSTEMS**

<b>Do you currently have any of the following problems?</b>	<b>Yes</b>	<b>No</b>	<b>If YES, please explain:</b>
Chronic fever, unexpected weight loss/gain, fatigue	_____	_____	_____
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)	_____	_____	_____
Heart problems (e.g. chest pain, irregular heart beat)	_____	_____	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	_____	_____	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	_____	_____	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	_____	_____	_____
Skin problems (e.g. rashes, excessive dryness)	_____	_____	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	_____	_____	_____
Neurologic problems (e.g. numbness, weakness, headaches, paralysis)	_____	_____	_____
Psychiatric problems (e.g. depression, anxiety)	_____	_____	_____

**FAMILY AND SOCIAL HISTORY**

- Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please explain: \_\_\_\_\_
- Do you smoke? If yes, how much? \_\_\_\_\_
- Do you drink alcohol? If yes, how much? \_\_\_\_\_

## PATIENT INFORMATION

Date \_\_\_\_\_ Referred By \_\_\_\_\_ Birth date \_\_\_\_\_  
Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (H) \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone (W) \_\_\_\_\_  
SS# \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Family Physician \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

E-mail address: \_\_\_\_\_

Do you want *appointment reminders* by: Phone \_\_\_\_\_ E-mail \_\_\_\_\_ (please check one)

### Insurance holder's information (Parent/Guardian/Guarantor Information)

Name \_\_\_\_\_ SS# \_\_\_\_\_ Birth date \_\_\_\_\_  
Address (if different) \_\_\_\_\_  
Phone (if different) \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

### Trust fund information (if applicable)

Trustee Name \_\_\_\_\_  
Trustee Address \_\_\_\_\_  
Trustee Phone number \_\_\_\_\_

### Insurance Information (Health and Vision Insurance)

Primary Insurance \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ ID # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_ ID # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

### Patient Signature Form

I request that payment of authorized insurance and/or Medicare benefits be made either to me or on my behalf to Donald A. Bollheimer, M.D., Susan L. Eggebrecht, O.D., or Eric. P. Purdy, M.D. I further request that any supplemental insurance benefits be filed on my behalf be paid as stated above. I authorize any holder of medical information about me to release to my insurance and/or the Health care Financing Administration (HCFA) and its agent any information needed to determine these benefits or the benefits payable for related services.

Patient/Parent signature \_\_\_\_\_ Date: \_\_\_\_\_