

MEDICAL HISTORY AND INSURANCE COVERAGE 2025 Form

Patient Name _____ Date ____/____/____
Address _____ Phone _____
City _____ State ____ Zip _____ Work Phone _____
Guardian (if applicable) _____ Occupation _____
Birthdate ____/____/____ Age _____ Last Eye Exam ____/____/____
Email _____

May we contact you via our HIPPA secure email? No Yes

You must show insurance cards at front desk check-in. We will need copies if we are billing to your Medicare or Medical.

Do you have vision insurance? No Yes If yes, insurance carrier EYEMED VSP Laborers Pipetrade

Member Name: _____ Member DOB ____/____/____

Member Last 4 digits of SSN (for VSP): _____

Do you have health insurance? No Yes If yes, insurance carrier _____

Member ID # _____

Do you have Medicare? No Yes Medicare ID # _____

Primary care doctor's name: _____ Name of Doctor office _____

Medical History

List medications you take (including oral contraceptives, aspirin, over the counter medications, and home remedies)

Do you currently use a CPAP Machine? No Yes

Do you have any allergies to medication? No Yes

If yes, explain: _____

List all major injuries, surgeries, and/or hospitalizations you have had

Circle any of the following you have had/ have – refractive surgery, crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, eye injury

Are you pregnant and/or nursing? No Yes

Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? No Yes

Family History

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

Disease / Condition	Yes	Relationship	Disease / Condition	Yes	Relationship
Blindness	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	_____	Lupus	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	_____
Retinal Detach./Disease	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	_____			

Social History – This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer. Yes, I wish to discuss my social history information directly with the doctor.

Do you drive? No Yes If yes, do you have visual difficulty when driving at day or night? Day Night Both

Do you have vision restriction on your driver's license? No Yes

Are you on a digital device more than two hours a day? No Yes

Tobacco Use: Never Smoked Former Smoker Current Every Day Smoker Current Some Day Smoker

Alcohol Use: None Social Use Only 1-2 Drinks Daily Above Average Chemical Dependence

Illegal Street Drug Use: None Recreational Use Chemical Dependence

Marijuana Use (including edibles) None Recreational or Medical Use How often do you use? _____

Date of last use _____

Sexually Transmitted Disease: Gonorrhea Hepatitis HIV Syphilis Other _____

Review of Systems

Do you currently, or have you ever had any chronic problems in the following areas:

	Yes		Yes		Yes
Eyes		Ear, Nose, Mouth, Throat		Genitourinary	
Loss of Vision	<input type="checkbox"/>	Allergies / Hay Fever	<input type="checkbox"/>	Genitals / Kidney / Bladder	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	Constitutional	
Distorted Vision / Halos	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	Fever, Weight Loss / Gain	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	Integumentary	
Double Vision	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	Skin	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	Dry Throat / Mouth	<input type="checkbox"/>	Neurological	
Mucous Discharge	<input type="checkbox"/>	Respiratory		Headaches	<input type="checkbox"/>
Redness	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Migraines	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Itching	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Bones / Joints / Muscle	
Burning	<input type="checkbox"/>	Vascular / Cardiovascular		Rheumatoid Arthritis	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	Diabetes Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/>		Muscle Pain	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>
Glare / Light Sensitivity	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Lymphatic / Hematological	
Eye Pain or Soreness	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Chronic Infect. of Eye or Lid	<input type="checkbox"/>	Gastrointestinal		Bleeding Problems	<input type="checkbox"/>
Stye or Chalazion	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>	Allergic / Immunologic	<input type="checkbox"/>
Flashes / Floaters in Vision	<input type="checkbox"/>	Chronic Constipation	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	Endocrine			
		Thyroid / Other Glands	<input type="checkbox"/>		

If you answered yes to any of the above, or have a condition(s) not listed, please list/explain:

Examining Doctor Signature

Date