PATIENT HISTORY FORM

Name	Social Security Number	Gender	Todays Date
Address, City, State, ZIP		Height	Weight
Email	Telephone Number (Circle One: Home, Work, Mobile or Other)	Age	Date of Birth
Employment (Or nature of disability)		Race, Ethnicity, and Preferred Language	

Personal & Family Eye History

*Please check all that apply and explain

*Date of Last Eye Exam: _____

- ☐ Cataracts _____
- ☐ Glaucoma _____
- ☐ Detached Retina _____
- ☐ Contact Lenses: Hard/ Soft_____
- ☐ Diabetic Retinopathy _____
- ☐ Macular Degeneration _____
- ☐ Glasses for Distance/ Near _____
- ☐ Laser or Ocular Surgery: _____

*Please list any **eye medications**, including over-the-counter:

_____

General Health History

*Please check all of the conditions that **YOU** have and explain

- ☐ No personal health problems
- ☐ Fever or Weight Loss_____
- ☐ Ears, mouth, nose, throat problem
- ☐ Sinus disease_____
- ☐ High blood pressure_____
- ☐ Irregular heart beat_____
- ☐ Other heart disease_____
- ☐ Asthma or emphysema_____
- ☐ Skin disorders_____
- ☐ Headaches_____
- ☐ Cancer_____
- ☐ Liver Disease, Hepatitis_____
- ☐ Kidney, urinary or genital diseases
- ☐ Joint or muscle pain_____
- ☐ Stroke or neurological disease___
- ☐ Blood disorders_____
- ☐ HIV or AIDS_____
- ☐ Other Lung Disease_____
- ☐ Diabetes or thyroid disease_____
- ☐ Stomach or intestinal problems___
- ☐ Seasonal Allergies_____
- ☐ Reaction to Anesthetics_____
- ☐ Psychiatric problems_____
- ☐ Do you currently smoke cigarettes
  - If yes, how much?_____
- ☐ Have you ever smoked cigarettes?
  - If yes, how many years?_____
  - If yes, when did you quit?_____
- ☐ Have you ever been exposed to TB? Y or N
- ☐ Are you currently pregnant or nursing? Y or N
- ☐ Other: _____
  _____

Current Symptoms

*Please check all of **YOUR** conditions that currently apply

- ☐ **General:** Weight Change, Fatigue, Fever, Weakness, etc.
- ☐ **Skin:** Rashes, Lumps, Itching, Dryness, Color Change, etc.
- ☐ **Head:** Headache, Head Injury, Neck Pain, etc.
- ☐ **Ears:** Decreased Hearing, Ringing, Earache, Drainage, etc.
- ☐ **Eyes:** Vision Loss, Pain, Redness, Blurry/Double Vision, Flashing Lights, Specks, etc.
- ☐ **Nose:** Stuffiness, Drainage, Sinus Pain, Nosebleeds, etc.
- ☐ **Throat:** Bleeding, Dentures, Sore, Dry Mouth, Thrush, etc.
- ☐ **Neck:** Lumps, Swollen Glands, Pain, Stiffness, etc.
- ☐ **Breasts:** Nursing, Lumps, Pain, Discharge, etc.
- ☐ **Respiratory:** Cough, Wheezing, Painful Breathing, etc.
- ☐ **Cardiovascular:** Chest Pain, Tightness,Palpitations, Shortness of Breath, Swelling, etc.
- ☐ **Gastrointestinal:** Difficulty Swallowing, Heartburn, Change in Appetite, Nausea, Diarrhea, Bleeding, Constipation, etc.
- ☐ **Urinary:** Urgency, Frequency, Burning, Blood, etc.
- ☐ **Vascular:** Calf Pain, Leg Cramping, etc.
- ☐ **Musculoskeletal:** Muscle and/or Joint Pain, Stiffness, Back Pain, Swelling and/or Redness of Joints, Trauma, etc.
- ☐ **Neurologic**: Dizziness, Fainting, Seizures, Weakness, Numbness, Tingling, Tremor, etc.
- ☐ **Hematologic:** Ease of Bruising and/or Bleeding, etc.
- ☐ **Endocrine:** Head or Cold Intolerance, Sweating, Frequent Urination, Thirst, Change in Appetite, etc.
- ☐ **Psychiatric:** Nervousness, Stress, Depression, Memory Loss, etc.

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* Please list any **allergies** you have:

_____

* Please list **any prescription and over-the counter medications** you are currently taking:

_____

Primary Care Provider

*Please list the name of your current primary care physician/doctor

_____ _____ _____

(Name) (Phone Number) (Address)

Referral Information

*How did you hear about us (Circle All that Apply)?

Newspaper Website Facebook Insurance Friend_____ Other_____

Signature

*Please read and sign where noted below

Signature on File:
I am responsible for payment at the time of each visit for all services provided by Aris Eye Care P.C. not covered by an insurer. My signature serves as a "signature on file" for **claim processing** and for release of medical information to my insurance carrier(s).

_____ _____ _____

Signature of patient or person authorized to sign for patient **Today's Date** **Relationship to Patient**

Acknowledgement of Receipt:
I acknowledge that I received a copy of Aris Eye Care P.C.'s Notice of Privacy Practices.

_____ _____ _____

Signature of patient or person authorized to sign for patient **Today's Date** **Relationship to Patient**

Dilation:

A dilated eye exam is an essential part of a thorough eye health evaluation. Eye drops are used to open your pupil to allow a clear view of the nerve, blood vessels, and tissue in the back of your eye. This is important for detecting eye diseases such as cataracts, glaucoma, and macular degeneration among others. The eye drops used have a very low risk of adverse health events including allergic reaction. The side effects of these drops include sensitivity to light and difficulty with near tasks. In addition, some patients may experience headache and eyestrain afterward. It is recommended that you have a driver, however some patients may not require assistance. (Choose one option from below)

I **agree** to be dilated today.

_____ _____ _____

Signature of patient or person authorized to sign for patient **Today's Date** **Relationship to Patient**

I have been educated regarding the importance of a dilated eye exam. I have **refused** to have this conducted today.

_____ _____ _____

Signature of patient or person authorized to sign for patient **Today's Date** **Relationship to Patient**

Documentation of Failure to Obtain Signed Acknowledgement:
On _____, _____ presented Receipt of Notice of Privacy Practices form to _____. The patient refused to provide a signature.
Today's Date **Name** **Name of Pt**