PATIENT HISTORY Today's Date _____________

Last Name: _____________________ First Name:_______________ MI:______ Suffix:_____________
Address:_____________________________________ Marital Status: Sgl M D W Separated
City:_______________ State:___ Zip:_______ Race:_______ Ethnicity:__________
Work Ph: ___________________ Cell/Home Ph: _______________ Social Security# : _____________________
Date of Birth:_____________ Age:____ Sex: M F
Employer:____________________ Occupation: _____________ **EMAIL:** __________________________________
Guarantor/Emergency Contact:_____________________________________ Phone: ____________________________
Insurance Company __________________Primary Policy Holder _______________________*SS#__________________
Policy Holder DOB_________ Employer___________Address if different ____
Patient's Relationship to Policy Holder (circle one): Self Spouse Child

MEDICAL HISTORY: CIRCLE CONDITIONS THAT APPLY TO YOU: **PREFERRED PHARMACY**: ________________

~ Asthma	~ Headaches	~ Arthritis	~ Lupus
~ High Blood Pressure	~ Crohn's / Gastrointestinal	~ Depression / Mental	~ Seizures
~ Diabetes	~ Multiple Sclerosis / Neuro	~ Cancer (Type _________)	~ Kidney Dz
~ Thyroid	~ Anemia / Blood Disorder	~ Seasonal Allergies	~ Liver Dz / Hepatitis
~ Heart Disease	~ High Cholesterol	~ HIV	

Other: ____
Primary Care Doctor: ____________________________________ Do you smoke? Yes/No Amt per day __________
Consume Alcohol? Yes/No Freq _______ Use illegal drugs? Yes/No
Past Surgery/Surgeries & Year:____
Current Medication(s)____
____
Allergies to Med(s)________________________________ Female Patients: Are you pregnant? Yes No Nursing: Yes/No

OCULAR HISTORY

Date of last exam ____________________________
DO YOU HAVE OR HAVE YOU BEEN DIAGNOSED WITH: (PLEASE CIRCLE)

~ Glaucoma	~ Cataracts	
~ Eye Surgery	~ Dry Eyes	~ Flashes/Floaters
~ Loss of Vision	~ Macular Degeneration	~ Eye Allergies
~ Eye Injury	~ Retinal Detachment	~ Glare/Light Sensitivity

FAMILY HISTORY

(PLEASE CIRCLE)	RELATION		RELATION
~High Blood Pressure	__________	~Glaucoma	__________
~Diabetes	__________	~Blindness	__________
~Stroke	__________	~Macular Degeneration	__________
~Cataract	__________	~Retinal Detachment	__________

Do you have more than one pair of current RX glasses? YES NO   Do you spend a lot of time outdoors? YES NO
Do you work on the computer for long periods? YES NO   Do you wear sunglasses outside? YES NO
Are you satisfied with your current contact lenses? YES NO

**I have read and understand the HIPAA Notice of Privacy Practices ____
(Privacy Practices available upon request) ****Signature****

**I authorize ins. benefits made to: Mooresville Eye Care, OD, PLLC ____
****Signature****