Patient Information & History Form

Name_____
(Last Name) (First Name) (M.I.)

Address_____

City_____ **State**_____ **Zip**_____

Date of Birth_____ ☐Male ☐Female ☐Single ☐Married

Date_____

Home Phone (_____)_____

Cell Phone (_____)_____

Email_____

Employer_____

Position_____

Insurance

Do you have **VISION INSURANCE**? ☐Yes ☐No Insurance company_____

Do you have **HEALTH INSURANCE**? ☐Yes ☐No Insurance company_____

Do you have **MEDICARE**? ☐Yes ☐No Supplemental Insurance company_____

History

Have you ever seen Dr. McLaughlin before? ☐Yes ☐No

When was your last Eye Exam?_____ Where?_____

Do you wear glasses? ☐Yes ☐No

Do you wear contact lenses? ☐Yes What brand?_____ Are they comfortable? ☐Yes ☐No
☐No Are you interested in contacts today? ☐Yes ☐No

What is the main reason for your visit today?_____

Ocular History:

Check all that apply to you (now or in the past)

Eye Conditions
- ☐ cataract
- ☐ macular degeneration
- ☐ glaucoma
- ☐ diabetes
- ☐ diabetic retinopathy
- ☐ dry eyes
- ☐ eye infection, inflammation, or allergy
- ☐ floaters and/or flashes of light
- ☐ iritis or uveitis
- ☐ retina defects or degeneration
- ☐ lazy eye

Eye Concerns
- ☐ redness
- ☐ burning
- ☐ itching
- ☐ tearing
- ☐ discharge

Vision Concerns
- ☐ blurred vision
- ☐ eyestrain
- ☐ eye pain
- ☐ severe sensitivity to light
- ☐ headache
- ☐ poor night vision
- ☐ bothersome night glare
- ☐ double vision
- ☐ total loss of vision

PLEASE COMPLETE BACK OF THIS FORM

Current medications:_____

_____

Drug allergies:_____

Review of Systems:

Check all that apply to you (now or in the past):

Constitution
□ developmental disabilities
□ cancer
□ fatigue syndrome

ENT
□ hearing loss
□ sinusitis
□ dry mouth
□ laryngitis

Neurological
□ multiple sclerosis
□ epilepsy
□ cerebral palsy
□ tumor
□ stroke
□ migraine

Psychiatric
□ depression
□ attention deficit
□ anxiety disorder
□ bipolar disorder

Cardiovascular
□ high blood pressure
□ stroke
□ heart disease
□ vascular disease
□ congestive heart failure

Respiratory
□ cigarette smoker
□ asthma
□ bronchitis
□ emphysema
□ COPD
□ sleep apnea

Gastrointestinal
□ crohn's disease
□ colitis
□ ulcer
□ acid reflux
□ celiac disease

Genitourinary
□ kidney disease
□ prostate disease/cancer
□ STD-herpetic/chlamydia
□ pregnant/nursing

Musculoskeletal
□ arthritis
□ osteoarthritis
□ fibromyalgia
□ muscular dystrophy
□ ankylosing spondylitis
□ osteoporosis
□ gout

Integumentary
□ eczema
□ rosacea
□ psoriasis
□ herpes simplex (cold sores)
□ herpes zoster (shingles)

Endocrine
□ type II diabetes
□ type I diabetes
□ thyroid dysfunction
□ hormonal dysfunction

Hematological/Lymphatic
□ anemia
□ large volume blood loss
□ ulcer
□ high cholesterol

Allergic/Immune
□ drug allergies
□ environmental allergies
□ rheumatoid arthritis
□ lupus
□ Sjorgren's syndrome

Please **circle** all relatives to which each condition applies:

Family Medical History:

Cancer	*Father*	*Mother*	*Brother*	*Sister*	*Son*	*Daughter*
Diabetes Type I	*Father*	*Mother*	*Brother*	*Sister*	*Son*	*Daughter*
Diabetes Type II	*Father*	*Mother*	*Brother*	*Sister*	*Son*	*Daughter*
High Blood Pressure	*Father*	*Mother*	*Brother*	*Sister*	*Son*	*Daughter*
Thyroid Disease	*Father*	*Mother*	*Brother*	*Sister*	*Son*	*Daughter*

Family Ocular History:

Cataracts	*Father*	*Mother*	*Brother*	*Sister*	*Son*	*Daughter*
Macular Degeneration	*Father*	*Mother*	*Brother*	*Sister*	*Son*	*Daughter*
Glaucoma	*Father*	*Mother*	*Brother*	*Sister*	*Son*	*Daughter*

Social History:

Do you drink alcohol? □ Yes □ No

If yes, how much? _____

Do you smoke? □ Yes □ No

If yes, how much? _____

FEMALES ONLY:

Are you pregnant? □ Yes □ No

Are you nursing? □ Yes □ No

Patient Signature:_____ **Date:**_____

(Parent or Guardian if patient is a minor)

Professional Fees are due at time of service and are not refundable.

OFFICE POLICIES

Patient Name _____ Date _____
(Please Print)

Glasses and Contact Lens Prescriptions

Glasses prescriptions are normally issued at time of exam. Contact lens prescriptions are not given until a proper fit is established and all professional fees are paid. Contact lens prescriptions must be finalized within 30 days of the original exam date to avoid additional charges. Most people are able to wear contact lenses, but a successful fit and wearing experience cannot be guaranteed. Professional fees are not refundable and due when services are rendered.

Initial_____

Pupillary Dilation

For some patients pupillary dilation may be advised. This allows the doctor to better examine the retina for holes, tears, detachments, tumors (benign or malignant), etc. There is no additional charge for this procedure. Common side effects are increased glare and reduced near focusing ability. Distance vision is not as significantly affected so you should be able to drive. If you do not have sunglasses with you they will be provided. The process is painless and dilation lasts approximately 4 hours.

Please check one:

□ I agree to dilation if the doctor advises it.
□ I refuse dilation.

Initial_____

Patient Privacy

This office is bound by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This involves the release of personal medical information. We abide by all of these required laws. If you are not familiar with HIPAA, please ask us for a copy to read. I understand that my medical information will be safeguarded and will not be released without consent from the patient or guardian.

Initial_____

I have read, understand and agree to the office policies as stated above. I understand professional fees are not refundable and due at time of service.

Signature _____ Date _____