HEALTH HISTORY

Name: _____ Date: _____

GENERAL INFO

When was your last eye exam? _____ Where? _____

CIRCLE ALL THAT APPLY

Do you ever use **glasses**? Yes No If yes, any difficulty seeing distance or near? Yes No
If no, any difficulty seeing distance or near? Yes No

Do you ever use **contact lenses**? Yes No If yes, any difficulty seeing distance or near? Yes No
Interested in learning about the latest in contacts? Yes No

Do any of these give you trouble? Driving TV Movies Reading Needlework Computer Other _____

Do your eyes feel bad? Yes No / Burning Aching Tired Itchy Watery Dry Sandy/gritty

Are you sensitive to light? Yes No / Fluorescent Glare Night driving Snow Sun

Do you use a computer? Yes No / Work Home

Interested in learning more about **laser vision correction**? Yes No

CIRCLE IF "YES" (NO CIRCLE INDICATES "NO")

ABOUT YOUR FAMILY – THEIR EYES & GENERAL HEALTH

Cataracts	Yes	Diabetes	Yes	List any other health problems that
Glaucoma	Yes	High blood pressure	Yes	run in your family _____
Macular degeneration	Yes	Heart disease	Yes	_____
Retinal detachment	Yes	Stroke	Yes	_____
Blindness	Yes	Thyroid	Yes	_____
Other: _____		Arthritis	Yes	_____

ABOUT YOU – YOUR EYES

Cataracts	Yes	Blindness	Yes	Strabismus (eye turn)	Yes
Glaucoma	Yes	Injuries to eyes/head	Yes	Amblyopia (lazy eye)	Yes
Macular degeneration	Yes	Foreign body removed	Yes	Eye surgeries	Yes
Retinal detachment	Yes	Eye infections	Yes		

Over please!

ABOUT YOU – YOUR GENERAL HEALTH

General	
Recent weight change	Yes
Fever	Yes
Fatigue	Yes
Shortness of breath	Yes
Ear / Nose / Mouth / Throat	
Allergies / Hay fever	Yes
Chronic sinus problems	Yes
Chronic cough	Yes
Dry throat and mouth	Yes
Hearing loss	Yes
Skin	
Any skin condition	Yes
Breathing	
Asthma / Bronchitis	Yes
Emphysema	Yes
Nerves	
Migraines	Yes
Seizures	Yes
Multiple Sclerosis	Yes
Heart & Blood vessels	
Heart problems	Yes
High blood pressure	Yes
Stroke	Yes
High cholesterol	Yes
Bones / Joints / Muscles	
Arthritis	Yes
Fibromyalgia	Yes
Muscular Dystrophy	Yes

Stomach & Digestion	
Crohn's Disease	Yes
Ulcer	Yes
Genital & Urinary	
Urinary tract infections	Yes
Kidney problems	Yes
STD's (HIV, Herpes, Chlamydia)	Yes
Blood & Lymph	
Anemia	Yes
Leukemia	Yes
Bleeding problems	Yes
Glands	
Diabetes (insulin)	Yes
Diabetes (non-insulin)	Yes
Thyroid problems	Yes
Psychiatric	
Depression	Yes
Nervousness /Panic disorder	Yes
Bi-polar disorder	Yes
Allergy / Immune	
HIV / AIDS	Yes
Lupus	Yes
Cancer	Yes
Environmental / food allergy	Yes

Comments: _____
_____
_____

MEDICATIONS YOU TAKE

_____
_____
_____
_____

Pharmacy: _____

WHAT YOU ARE ALLERGIC TO

Medications: _____
_____
_____

Other: _____
_____

DO YOU HAVE MEDICARE? PLEASE SIGN.

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Richard C. Annis, O.D., P.C., for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on the Medicare insurance form or on any electronically submitted claim, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Medicare Beneficiary Date