Patient Medical Information

Today's Date_____

Last Name_____ First Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Date of Birth_____ Occupation_____ Your Email_____

Other Family Members Seen in Our Office_____ Last 4 of SSN_____

Date of Last Eye Exam_____ Dilated? ☐ Yes ☐ No Referred By_____

Primary Vision Insurance: ☐ VSP ☐ MES ☐ EyeMed ☐ Other_____ Secondary Vision Insurance_____

Medical Insurance: ☐ HMO ☐ PPO Primary Carrier_____ Secondary Carrier_____

Primary Insured Name_____

Medical Information

Do you have any problems with any of the following systems? (Please check Yes or No)

Gastrointestinal	☐ Yes	☐ No	Nervous	☐ Yes	☐ No	Endocrine(glands)	☐ Yes	☐ No
Ear/Nose/Throat	☐ Yes	☐ No	Urinary	☐ Yes	☐ No	Blood/Lymph	☐ Yes	☐ No
Cardiovascular	☐ Yes	☐ No	Muscles/Bones	☐ Yes	☐ No	Allergic/Immunologic	☐ Yes	☐ No
Respiratory	☐ Yes	☐ No	Skin	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Blood Pressure	☐ Yes	☐ No	Eyes	☐ Yes	☐ No	Mental	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Type_____	Date of Diagnosis_____	

Current Medications_____

_____

Allergies to Medications? ☐ Yes ☐ No Please list_____

Other Health Problems_____

Have you had any operations? ☐ Yes ☐ No Please list (with date)_____

Name of family doctor_____ Date of Last Visit_____

Do you smoke? ☐ Yes ☐ No Average # of alcoholic beverages/week_____

Family History

High Blood Pressure	☐ Yes ☐ No | Relation_____	Macular Degeneration	☐ Yes ☐ No | Relation_____
Diabetes	☐ Yes ☐ No | Relation_____	Retinal Detachment	☐ Yes ☐ No | Relation_____
Glaucoma	☐ Yes ☐ No | Relation_____	Cataracts	☐ Yes ☐ No | Relation_____

Personal Eye Information

Have you had any eye operations? ☐ Yes ☐ No Type_____

Have you had any eye injuries? ☐ Yes ☐ No Type_____

Do you have Glaucoma?	☐ Yes ☐ No	Cataracts?	☐ Yes ☐ No	Dry/Itchy Eyes	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	Retinal Detachment	☐ Yes ☐ No	Blurred Vision	☐ Yes ☐ No
Do you wear glasses?	☐ Yes ☐ No	If yes, when?_____		Do you wear contact Lenses?	☐ Yes ☐ No Type_____

Additional Information_____

_____

PLEASE READ AND SIGN:

Contact Lens Wearers: Contact Lens wearers require additional time, testing, consultation, and expertise. Therefore, a separate contact lens evaluation or fitting fee will be applied for both new and existing contact lens wearers.

Patients Using Vision or Medical Insurance: I request that payment of authorized vision or medical insurance benefits be made directly to Dr. Lori L. Floyd, OD, Inc for any goods or services furnished. I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination and care. I understand that I am financially responsible for all charges, whether or not paid by insurance. Payment is due at the time services are rendered.

Privacy Policy: I am aware that the Notice of Privacy Practices is available to view on the practice website (www.drlorifloyd.com), or a copy may be obtained from the office staff.

Signature_____ Date_____