Hometown Eyecare and Optical, LLC

Patient Information

Name: _____
Address: _____
City, Zip _____

Please place a check in the box indicating your preferred phone #
[ ] Home Phone: _____
[ ] Cell Phone: _____
[ ] Work Phone: _____

Social Security Number:_____
Date of Birth: _____
Sex: ___ Male ___Female
Employer/School: _____
Occupation: _____
Head of Household: _____

Patient Medical History

Name of Medical Doctor: _____

Please check any conditions that apply to you

Constitution
___ Developmental Disabilities
___ Cancer

Ear/Nose/Throat
___ Hearing Loss
___ Sinusitis
___ Other_____

Neurological
___ Multiple Scleroisis
___ Migraine
___ Autism Spectrum Disorder
___ Other_____

Psychological
___ Depression
___ Attention Deficit
___ Anxiety Disorder
___ Other_____

Cardiovascular
___ High Blood Pressure
___ Stroke
___ Heart Disease
___ Congestive Heart Failure
___ Other_____

Respiratory
___ Asthma
___ Emphysema
___ Sleep Apnea
___ Other_____

Gastrointestinal
___ Ulcers
___ Acid Reflux/Gerd
___ Celiac Disease
___ Other_____

Genitourinary
___ Kidney Disease
___ Prostate Cancer
___ Benign Prostate Hypertrophy
___ STD
___ Other_____

Musculoskeletal
___ Arthritis
___ Fibromyalgia
___ Muscular dystrophy
___ Osteoporosis
___ Gout
___ Other_____

Integumentary/Skin
___ Eczema
___ Rosacea
___ Psoriasis
___ Herpes Simplex/Cold sores
___ Herpes Zoster (Shingles)
___ Other_____

Endocrine
___ Type 1 Diabetes
___ Type 2 Diabetes
___ Thyroid Dysfunction
___ Hormone Dysfunction
___ Other_____

Hemotologic/Lymphatic
___ Anemia
___ Blood loss
___ High Cholesterol
___ Other_____

Immune System
___ AIDS
___ Lupus
___ Sjogren's Syndrome
___ Other_____

Are you pregnant or nursing [ ] Yes [ ] No

Are you allergic to any medications? [ ] Yes [ ] No
If yes, what medications?_____

Please list any other allergies (food, environmental, etc.) _____

Hometown Eyecare and Optical, LLC

Have you ever experienced or been diagnosed with any of the following? (Please check)

___ Glaucoma ___ Double Vision ___ Eye Infections ___ Flashes of Light in your vision
___ Cataracts ___ Crossed Eye/Eye turn ___ Watery Eyes ___ Floaters in your vision
___ Macular Degeneration ___ Amblyopia ___ Chronic Headaches ___ Dry/Itchy Eyes
___ Retinal Detachment ___ Keratoconus
___ Eye Injury (please explain)_____
___ Eye Surgery (please explain)_____
___ Other_____

Do you use: (please circle) [ ] *Check if none of these apply to you*

Alcohol Chewing tobacco Cigarettes Cigars Pipes Vaping Former smoker

Current Medications (Rx or Over the Counter) Please list any medications you are currently using

Medication	Dose	What do you take this for?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Family</u> Medical and Eye History

Please note who of your **Parents, Siblings, or Children** have any of the following:

Cancer _____ Hypo Thyroid _____
Type 1 Diabetes _____ Cataracts _____
Type 2 Diabetes _____ Macular Degeneration _____
High Blood Pressure _____ Glaucoma _____
Hyper Thyroid _____ Retinal Detachment _____
Other Significant family history (Please specify) _____

Please indicate that you understand and agree to the following: (Parent/guardian initial for minor patient)

_____I acknowledge that I have been given a copy of and have reviewed Hometown Eyecare and Optical's Notice of Privacy Practices.

_____I give Dr. Walton and his staff consent to view my prescription medications claims history and I understand that they will have access to this history through an online pharmacy database until I choose to revoke this consent.

_____I request that payment of authorized insurance benefits for any services provided on my behalf be made to Hometown Eyecare and Optical, LLC. I authorize any holder of medical information about me to release to my insurance companies, and their agents, any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for charges for services not covered by my insurance. This may include fees for digital retinal imaging, refraction, contact lens fitting, and ophthalmic materials depending on my insurance.

Patient Signature
(Or Guardian if patient is a minor) _____ **Date** _____