Personal Health History

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

Cardiovascular	YES	NO
Heart Disease	⧉	⧉
Shortness of Breath	⧉	⧉
High Blood Pressure	⧉	⧉
Heart Attack	⧉	⧉
Constitutional		
Weight Loss	⧉	⧉
Weight Gain	⧉	⧉
Endocrine		
Diabetes	⧉	⧉
Thyroid Disease	⧉	⧉
Gastrointestinal		
Stomach Problems	⧉	⧉
Ulcer Disease	⧉	⧉
Genitourinary	YES	NO
Kidney Problems	⧉	⧉
Prostate Problems	⧉	⧉

Ear, Nose & Throat	YES	NO
Ear Problems	⧉	⧉
Sinus/Allergy Problems	⧉	⧉
Headaches	⧉	⧉
Migraines	⧉	⧉
Hematology		
Anemia	⧉	⧉
Hepatitis/Jaundice	⧉	⧉
Sickle Cell or Trait	⧉	⧉
Cancer	⧉	⧉
Immunologic		
HIV Positive	⧉	⧉
AIDS	⧉	⧉
Skin		
Rosacea	⧉	⧉
Skin Cancer	⧉	⧉

Musculoskeletal	YES	NO
Arthritis	⧉	⧉
Back Problems	⧉	⧉
Neck Problems	⧉	⧉
Neurology		
Stroke	⧉	⧉
Seizures/Convulsions	⧉	⧉
Epilepsy	⧉	⧉
Mental Status		
ADD	⧉	⧉
ADHD	⧉	⧉
Alcoholism	⧉	⧉
Drug Addiction	⧉	⧉
Pulmonary		
Asthma	⧉	⧉
Emphysema	⧉	⧉

	YES	NO
Blurred Vision-Distance/Near	⧉ **Dist.**	⧉ **Near**
Fluctuating Vision	⧉	⧉
"Tired Eyes"	⧉	⧉
Dry Eye (s)	⧉	⧉
Tearing/Redness/Discharge	⧉	⧉
Itching/Burning/Gritty Feeling	⧉	⧉
Eyelid Swelling	⧉	⧉
Eye Turn/Lazy Eye	⧉	⧉
History of Eye Injury/Surgery	⧉	⧉
History of Seeing Floaters	⧉	⧉
Glaucoma	⧉	⧉
Pregnant	⧉	⧉
Double Vision	⧉	⧉

CONTACT LENS USE

How many years have you worn contact lens? _____

Interested in Contact Lenses? _____

(Please circle what type of contact lens you are wearing)

Soft Hard Toric Multifocal

Please list what Brand: _____

Are your contact lens comfortable? ⧉ **YES** ⧉ **NO**

Do you sleep in your contact lens? ⧉ **YES** ⧉ **NO**

How often do you change your contact lens?
(Please Circle) 1Day 2Weeks 1Month 3Months 6Months

Please list what contact lens solution(s) you use.

Please list any solution allergies_____

	YES	NO		YES	NO
Do you use recreational drugs?	⧉	⧉	Do you drink Alcohol?	⧉	⧉
Do you smoke?	⧉	⧉	Packs per day _____Number of years_____		

Has a member of your immediate family been diagnosed with any of the following? Please indicate on the lines below with:
"F" for Father , "**M**" for Mother, **"S"** for Sister , **"B"** for Brother, "**GF**" for Grandfather, and "**GM**" for Grandmother.

⧉ Blindness _____	⧉ Glaucoma _____	⧉ ARMD (Macular Degeneration_____	⧉ Eye Turn _____	⧉ Cataract _____
⧉ Hypertension _____	⧉ Diabetes _____	⧉ Cancer _____	⧉ Cardiovascular Disease (Heart) _____	

Please list any other eye problems/comments.

Height:_____ Weight:_____

Please list any medications you are taking.	**Please list any medications you are allergic to!**

Welcome to Southern Vision Care

Phone: 251-634-2144
Fax: 251-634-2145

Date: _____ Chart #_____

LAST NAME:_____ FIRST NAME:_____INITIAL:_____

PREFERRED NAME: _____ □ Mr. □ Mrs. □ Miss □ Ms □ Dr.

Address:_____City:_____

State:_____ Zip_____. Race:_____

Home Phone: _____Daytime Phone: _____Cell Phone: _____

Email: _____ □Male □Female Birth date: _____

Social Security #:_____ □Married □Single □Divorced □Widowed □Minor

Drivers License #_____State_____

Employer: _____ □Full Time □Part Time

Occupation: _____ Communication Preference (circle one) E-mail Postal Telephone

How did you hear about us? □Insurance Plan □Family □Friend □Close to home/work □Yellow Pages
□Doctor:_____ □Other:_____

PERSON RESPONSIBLE FOR ACCOUNT

LAST NAME:_____ FIRST NAME:_____ INITIAL:_____

RELATIONSHIP TO PATIENT: _____

Birthdate:_____ Social Security #:_____Phone#: _____

Address:_____City:_____State_____Zip_____
(If different than patient)

Vision Insurance Co._____ ID#_____

Subscriber's Name _____Subscriber's Date of Birth_____

Primary Medical Insurance_____ Secondary Medical Insurance_____

Person we should contact in case of an emergency _____

Relationship: _____Phone:_____

The above information is true to the best of my knowledge. Payment from my insurance is to be paid directly to Southern Vision Care. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company. Final determination can only be made after the claim is processed. My signature below also acknowledges that I have been offered/read Southern Vision Care's "Notice of Privacy Practices". I also understand that I am ultimately responsible for any charges incurred. I agree to be responsible for collection/attorney's fees in the event that my account is sent to collections. I authorize Southern Vision Care or my insurance company to release any information required to process my claims.

_____Date:_____
Signature of Patient, Parent, Gaurdian or Personal Representative.