PATIENT HISTORY FORM

DATE:____/____/____
Name of Insurance_____

First Name:_____MI:____ Last Name_____DOB:_____

SS#:____-____-____ E-mail_____Parent:_____

Address:_____City:_____State:_____ZIP:_____

Cell/Daytime phone:_____

Employer_____Occupation_____

Contact in case of emergency:_____Contact phone number_____

PERSONAL EYE INFORMATION

Date of last eye exam_____ Do you wear glasses Y/N Contacts Y/N
Do you have? Glaucoma Y___N____ Cataracts Y____N____Dry Eyes Y____N_____ Blurred Vision Y__N___
Have you had any eye operations Y__N__
Type_____Date_____
Have you had an eye injury? Y__N___
Type_____Date_____

MEDICAL INFORMATION

How is your general health?_____
Do you have problems with any of these systems?

Gastrointestional	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N
Endocrine(glands)	Y/N	Respiratory	Y/N	Integumentary (skin)	Y/N
Allergic/Immunologic	Y/N				

Please explain_____
Do you have Diabetes? Y/N Type_____ Date of Diagnosis_____ Headaches? Y/N
Are you allergic to any medications Y/N Please list
_____
Are you taking any prescription medications? Y/N Please list
_____
Have you had any operations? Y/N Please list _____Date _____
Name of Family Doctor_____Do you use ciggarettes/tobacco? Y/N Alcohol Y/N

FAMILY HISTORY

High blood pressure Y/N Relation_____ Macular degeneration Y/N Relation_____
Diabetes Y/N Relation_____ Retinal detachment Y/N Relation_____
Glaucoma Y/N Relation_____ Cataracts

Y/N Relation_____

Who may we thank for referring you?_____

The eye examination may require pupil dilation based on your symtoms, age, and health history. Dialation causes blurred vision and light sensitivity, which may impair your ability to drive. Please indicate your preference below.

___NO, i do not want my eyes dialated ___YES, I would like my eyes dialated

I UNDERSTAND THAT YOU WILL FILE MY INSURANCE AS A COURTESTY. I AGRESS TO PAY ANY CHARGES NOT COVERED BY INSURANCE

I ACKNOWLEDGE THAT I RECEIVED/READ A COPY OF DR. CHRISTOPHER C. FUSCO, OD 'NOTICE OF PRIVACY PRACTICES'

SIGNATURE_____DATE_____