Name: _____ Date of Birth: _____ M ☐ F ☐

Address: _____ City/State/Zip: _____ / _____ / _____

Phone Number: _____ Email: _____

Sponsor's Name: _____ Sponsor's DOB: _____ Spouse ☐ Child ☐ Other ☐

Sponsor's SSN/Patient's DBN: _____ Sponsor's Phone: _____

Sponsor's Address (if different from patient): _____

Patient's occupation: _____ Time spent on electronics per day: _____

How did you hear about us? _____ Patient is currently: Pregnant ☐ Nursing ☐ None ☐

Approximate date of last exam: _____ Patient has worn: Glasses ☐ Contacts ☐ None ☐

Reason for visiting today:

☐ Annual Examination ☐ Interested in Contacts ☐ Headaches ☐ Failed Vision Screening

☐ Lost or Broken Glasses ☐ Blurred Vision ☐ Eye Fatigue Other: _____

☐

Family History: ☐ None

☐ Cancer	☐ Marfan Syndrome	☐ Color Deficiency
☐ Celiac Disease	☐ Multiple Sclerosis	☐ Glaucoma
☐ Diabetes	☐ Neurofibromatosis	☐ Keratoconus
☐ Graves' Disease	☐ Rheumatoid Arthritis	☐ Macular Degeneration
☐ Heart Disease	☐ Sickle Cell Disease	☐ Retinal Diseases
☐ High Blood Pressure	☐ Stroke/HeartAttack	☐ Retinitis Pigmentosa
☐ High Cholesterol	☐ Tay-Sachs Disease	☐ Strabismus
☐ Lupus	☐ Thyroid	☐ **Unknown/Adopted**

Other:

Social History— Required by Medicare and most insurance companies.

Does the patient… ☐ None apply

…use tobacco products? Y ☐ N ☐ If so, indicate type/amount/duration: _____

…drink alcohol? Y ☐ N ☐ If so, indicate type/amount/duration: _____

…use illegal drugs? Y ☐ N ☐ If so, indicate type/amount/duration: _____

Has the patient ever been exposed to or infected with: ☐ None apply

Gonorrhea Y ☐ N ☐ HIV Y ☐ N ☐

Hepatitis A, B, or C Y ☐ N ☐ Syphillis Y ☐ N ☐

DOS: _____ Ins: _____ CPT: _____ Dx: _____ Verify: _____ Tech: _____

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DOS: _____ Ins: _____ CPT: _____ Dx: _____ Verify: _____ Tech: _____

DOS: _____ Ins: _____ CPT: _____ Dx: _____ Verify: _____ Tech: _____

Medications the patient is taking (i.e. oral contraceptives, aspirin, over the counter medication, & home remedies):

_____

List anything the patient is allergic to: _____

List any major eye injuries, surgeries, and/or conditions: _____

Review of Systems— Does the patient currently have or previously had any problems in the following areas?

☐ **No current health problems**

Ears/Nose/Mouth/Throat
- ☐ Allergies/hay fever
- ☐ Sinus congestion
- ☐ Dry throat/mouth

Endocrine
- ☐ Diabetes
- ☐ Thyroid
- ☐ PCOS

Eyes
- ☐ Loss of vision
- ☐ Dryness
- ☐ Mucous discharge
- ☐ Redness
- ☐ Sandy/gritty
- ☐ Itching/burning
- ☐ Sty/chalazion
- ☐ Flashes
- ☐ Floaters

Other (please list):

_____

Gastrointestinal
- ☐ Acid Reflux
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Collitis

Genetic
- ☐ Marfan Syndrome
- ☐ Neurofibromatosis
- ☐ Sickle Cell Disease
- ☐ Tay-Sachs Disease

Immunologic
- ☐ Celiac Disease
- ☐ Graves' Disease
- ☐ Lupus
- ☐ Multiple sclerosis
- ☐ Rheumatoid Arthritis

Integumentary
- ☐ Acne
- ☐ Eczema
- ☐ Ehlers-Danlos Syndrome

Joint/Muscles
- ☐ Gout
- ☐ Joint/muscle pain
- ☐ Osteoarthritis

Lymphatic/Hematologic
- ☐ Anemia
- ☐ Bleeding problems

Neurological
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures

Respiratory
- ☐ Asthma
- ☐ COPD/Emphysema

Sleep
- ☐ Sleep Apnea

Psychiatric
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Autism
- ☐ Bipolar Disorder
- ☐ Depression

Vascular/Cardiovascular
- ☐ Heart Attack
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Vascular disease

Does the patient have health coverage under another health plan? _____

Does the patient have health coverage under another vision insurance plan?_____

If the patient has another health insurance plan, Tricare will automatically become secondary. Payment will be due at the time of the eye exam, as the primary insurance must be billed first. I am aware that I am responsible for any examination fee not covered by my insurance and that professional fees are non-refundable. I acknowledge that I have been offered a copy of the privacy notice, and I authorize Family Optometric Associates, P.C. to release my medical record to Tricare/insurance company.

By signing below, I authorize Family Optometric Associates, P.C. to disclose my health/financial information as needed for continuity of care to the following listed individuals. This may be revoked only by a written or electronic note. I also understand that all glasses prescription rechecks, contact lens evaluations, and/ or follow-ups must be completed within 90 days of the original examination date.

_____ (Name) _____ (Relationship)

_____ (Name) _____ (Relationship)

_____ (Name) _____ (Relationship)

Patient(parent, if minor): x_____ Date: _____

Doctor: x_____ Date: _____