For Your Eyes Only

CHERIE S. LODL, O.D., P.C. & KAREN A. CULBERTSON, O.D., P.C.

PLEASE PRINT LEGIBLY

Name (legally given) _____ Nickname _____

Address (No PO Box)_____ City _____ State _____ Zip+4 _____

Phone # (Home) _____ (Work) _____ Sex ___ M ___ F DOB _____

Social Security # _____ Occupation _____

Employment Status (circle one) Employed full-time Employed part-time Not employed Self Employed Retired Active military duty

Student Status (circle one) Full-time student Part-time student Not a student **Height _____**

Marital Status (circle one) Divorced Legally separated Married Single Widowed **Weight _____**

E-Mail Address _____ May we contact you via e-mail? __Yes__ No

How did you hear about us? (circle one) Radio Phone Book Insurance Yellow Pages Friend/Relative/ Other/Professional _____

Preferred Language (circle one) English Spanish (First and Last Name)

Race (circle one) American Indian or Alaska Native Asian Black or African American Hispanic Native Hawaiian/Other Pacific Island White

Ethnicity (circle one) Hispanic or Latino Native Hawaiian/Other Pacific Island Not Hispanic or Latino

Communication Preference (circle one) Email Postal Telephone

Vision Complaints	**No**	**Yes**	**?**		**No**	**Yes**	**?**
Loss of Vision – Close Up or Far Away	☐	☐	☐	Burning	☐	☐	☐
Blurred Vision	☐	☐	☐	Foreign Body Sensation	☐	☐	☐
Distorted Vision/Halos Around Lights	☐	☐	☐	Excess Tearing /Watering	☐	☐	☐
Hazy or Foggy Vision	☐	☐	☐	Glare/Light Sensitivity	☐	☐	☐
Loss of Side Vision	☐	☐	☐	Eye Pain or Soreness	☐	☐	☐
Double Vision	☐	☐	☐	Chronic Infection of Eye or Lid	☐	☐	☐
Dryness	☐	☐	☐	Styes or Chalazion	☐	☐	☐
Mucous Discharge	☐	☐	☐	Flashes/Spots in Vision	☐	☐	☐
Redness	☐	☐	☐	Tired Eyes	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐	Crusted Lids	☐	☐	☐
Itching	☐	☐	☐	Headaches	☐	☐	☐

Medical History

List any of the following that you have had – crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, eye injury or eye surgeries_____

List recent injuries, surgeries, and /or hospitalizations you have had_____

Are you pregnant and/or nursing? ☐ No ☐ Yes

WHEN WAS YOUR LAST EYE EXAMINATION? _____ WHO WAS YOUR EYE DOCTOR? _____

WHEN WAS YOUR LAST GENERAL PHYSICAL? _____ WHO WAS YOUR PHYSICIAN? _____

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair or lenses?_____

Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?_____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ No ☐ Yes

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe:_____

Do you have vision insurance? ☐ No ☐ Yes If yes, insurance carrier_____

Do you have health insurance? ☐ No ☐ Yes If yes, insurance carrier_____

Do you have Medicare? ☐ No ☐ Yes Supplemental Plan? ☐ No ☐ Yes _____

(over)

Family History -- Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	?	Relationship	Maternal	Paternal
Arthritis/Rheumatism	☐	☐	☐		☐	☐
Cancer, Type	☐	☐	☐		☐	☐
Diabetes	☐	☐	☐		☐	☐
Heart Disease	☐	☐	☐		☐	☐
High Blood Pressure	☐	☐	☐		☐	☐
Kidney Disease	☐	☐	☐		☐	☐
High Cholesterol	☐	☐	☐		☐	☐
Thyroid Disease	☐	☐	☐		☐	☐
Blindness	☐	☐	☐		☐	☐
Cataract	☐	☐	☐		☐	☐
Crossed Eyes	☐	☐	☐		☐	☐
Glaucoma	☐	☐	☐		☐	☐
Macular Degeneration	☐	☐	☐		☐	☐
Retinal Detachment/Disease	☐	☐	☐		☐	☐
Other	☐	☐	☐		☐	☐

Social History

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long_____

Do you drink alcohol? ☐ No ☐ Yes If yes, socially … daily/weekly/monthly_____

Review of Systems – Do you have any problems in the following areas?

	No	Yes	?
Allergic/Immunologic	☐	☐	☐
Cardiovascular			
Heart Pain (Angina)	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Cardiovascular Disease	☐	☐	☐
Endocrine			
Diabetes	☐	☐	☐
Thyroid/Other Glands	☐	☐	☐
Ear, Nose, Mouth, Throat			
Sinusitis	☐	☐	☐
Chronic Cough	☐	☐	☐
Lymphatic Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐

	No	Yes	?
Integumentary (Skin)			
Acne	☐	☐	☐
Rosacea	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐

If you answered yes to any of the above, or have a condition not listed, please explain and list medications (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)_____

_____

Do you have any allergies or allergies to medication? ☐ No ☐ Yes If yes, please explain_____

_____

In Case of Emergency

Contact_____

Phone_____Relationship_____

INSURANCE -- I request payment for my eye care services be sought from my insurance company. I authorize release of any information necessary to my insurance company in order to determine eligible benefits. In the event my insurance carrier denies payment for these services I will be held responsible for all charges incurred. Any co-payments for non-covered services or products are expected when service is provided. Fees for contact lens evaluations and fittings are normally not covered by insurance plans and are the responsibility of the individual. If you have any questions about your specific insurance plan, please ask our receptionist **BEFORE** services are rendered.

PATIENT NAME _____ SIGNATURE _____ DATE _____

PAYMENT IS EXPECTED WHEN SERVICE IS PROVIDED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. ALL PAYMENTS WILL BE MADE TO **FOR YOUR EYES ONLY**. PLEASE NOTIFY US OF ANY COUPON OR INSURANCE DISCOUNTS YOU BELIEVE YOU ARE ENTITLED TO **BEFORE** SERVICE IS PROVIDED. DISCOUNTS AND/OR REFUNDS WILL NOT BE MADE AFTER TRANSACTIONS HAVE BEEN COMPLETED.

PATIENT NAME _____ SIGNATURE _____ DATE _____