BIG SKY EYES

Welcome Health History Form

Today's Date: _____/_____/_____

This information will assist us in giving you the best vision care possible. All information will be kept strictly confidential. Welcome to our office!

Name: ____ Date of Birth: _____/_____/_____
Parent or Guardian (if minor): ____
Mailing Address: _________________________________ City: ________________State: ______ Zip: ___________
Email: ____ SS# (last four): ___________
Cell Phone: (______)________________________ Optional Other Phone: (______)________________________

Vision Insurance (circle one): VSP / Eyemed / Other: ____
Medical Insurance: BCBS / Medicare / Other: ___________________________________ HMO or PPO (circle)?
Last Four of SS# of primary insured family member (if different from above): ____________________________
Primary Care Physician: ____________________________________ Date of last physical exam: ______________
Date of last eye exam: ____Are you pregnant or nursing: ☐Y ☐N
How did you hear about us?: ____

Medicare Questions: Do you drink? ☐Y ☐N How much: ☐Rarely. ☐Socially ☐Dependent
Do you smoke? ☐Y ☐N How much? __________ Do you use illegal drugs? ☐Y ☐N How much? __________
Height: _______ft _______ in Weight: _____lbs

Do you have any eye or vision concerns?:____
Occupation: __________________________________ Sports/hobbies: _______________________________________
How many hours do you use electronics/computers per day?: ☐ 0-2hrs ☐ 2-4hrs ☐ 4-6hrs ☐ more than 6hrs
Do you currently wear glasses?: ☐Y ☐N contact lenses?: ☐Y ☐N Type: ___________________________________
List all past eye injuries, infections, and diagnosis:
____

Dry/Allergic Eye Questionnaire: Severity of Symptoms

Symptoms	None	Tolerable	Bothersome	Intolerable
Dry / Grittiness				
Burning				
Watering				
Itchiness				
Eye Fatigue				

Any other ocular conditions:____
List all current medications:____
List all medical allergies: ____
List all past major past injuries, surgeries, and hospitalizations:
____

Have you or anyone in your family been diagnosed with:

Disease / Condition	Yes or Unsure	Family History & Relationship to You	Additional Information
Blindness or loss of vision	☐Y ☐?		
Cataract	☐Y ☐?		
Glaucoma	☐Y ☐?		
Macular Degeneration	☐Y ☐?		
Amblyopia (lazy eye)	☐Y ☐?		
Strabismus (crossed eyes)	☐Y ☐?		
Double Vision	☐Y ☐?		
Diabetic Retinopathy	☐Y ☐?		

Health Overview:

Disease / Condition (Circle)	Check if Yes	Explanation
General Health: fever, weight loss, headache		
Ear, Nose, and Throat: sinus congestion, hearing loss, postnasal drip, ringing in ears		
Cardiovascular: high blood pressure, chest pain, irregular heartbeat		
Respiratory: shortness of breath, COPD, asthma, chronic cough		
Gastrointestinal: constipation, diarrhea, IBS, Crohn's disease		
Genital, Kidney, Bladder: difficulty urinating, increased urination, thirst, or appetite		
Muscles, Bones, Joints: joint pain, arthritis, restriction of motion		
Skin: eczema, rosacea, rashes		
Neurological: dizziness, muscle weakness, tingling extremities, poor balance, seizures, faint		
Psychiatric: depression, anxiety, bipolar, schizophrenia		
Endocrine: diabetes, hyper or hypothyroid		
Blood, Lymph: anemia, excessive bleeding, swollen glands		
Allergic, Immunologic: rheumatoid arthritis, Crohn's disease lupus, ankylosing spondylitis, history of infectious disease		

Any other diseases/conditions:
____

I consent to the use or disclosure of my protected health information to the office of Big Sky Eyes for the purpose of diagnosing or providing treatment for me, obtaining payment for my health care bills, or to conduct the health care operations of the office of Big Sky Eyes.

I acknowledge that payment is due at the same time of treatment and I accept full financial responsibility for all charges provided to me or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relive me from my responsibility for the payment of all charges. I verify that the information on this page is accurate.

Signature:____ Date: ____________________

Updated Date:_______________ Updated Date:_______________ Updated Date:________________