Health History

Name_____ Age_____

Reason for today's exam_____

Do you or anyone in your immediate family have a history of the following?

☐Diabetes	☐Blindness	☐High Blood Pressure
☐Cataracts	☐Thyroid	☐Turned or lazy eye
☐Glaucoma	☐Heart Condition	

Who has had this/these above conditions? _____

Please check any of the following conditions that apply to you:

☐Frequent headaches	☐Drug allergies	☐Pregnant
☐Allergies	☐Sinus trouble	☐Have given birth in the last 6 months?

Please list all medications you are currently taking: _____
Are you allergic to any medications? _____

Have you ever had any of the following conditions involving your eyes?

☐Eye Surgery	☐Sensitivity to light	☐Eye infection or disease
☐Eye injury	☐Floaters or spots	☐Double vision
☐Medical treatment	☐Poor distance vision	☐Eye Strain
☐Severe pain	☐Poor near vision	☐Eyes burn, itch, or water

Do you currently wear glasses? ☐ Yes ☐ No
When do you wear your glasses?

☐All the time	☐Reading/near work
☐Work safety	☐Distance tasks only
☐Computer Work	☐Other, please explain _____

Have you ever worn contacts? ☐ Yes ☐ No
Are you interested in wearing contact lenses? ☐ Yes ☐ No
If so, what style?

☐Soft	☐Extended Wear	☐Gas Permeable	☐Bifocal
☐Tinted	☐Astigmatic	☐Disposable	☐Unsure

Do you work at a computer or video display terminal? ☐ Yes ☐ No

What hobbies or sports do you participate in? _____

Are you interested in Lasik? ☐ Yes ☐ No

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to Dr. Mark A. Gottlieb, O.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Rep. Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Rep. Relationship to Patient