_____

Patient Initials

Please Check All That Apply

Current Eye Symptoms / Conditions

☐ **None**

☐ Distance Vision Blurred
☐ Near Vision Blurred
☐ Floaters / Spots
☐ Amblyopia / Lazy Eye
☐ Tired Eyes
☐ Headaches
☐ Excess Tearing
☐ Dryness
☐ Glare / Light Sensitivity
☐ Foreign Body Sensation
☐ Eye Pain / Soreness
☐ Sandy / Gritty Feeling
☐ Itching
☐ Redness
☐ Mucous Discharge
☐ Retinal Detachment
☐ Glaucoma / Ocular Hypertension
☐ Loss of Side Vision
☐ Macular Degeneration
☐ Vision Distortions

Other: _____

Personal History

☐ **None**

Cardiovascular
☐ Elevated Cholesterol
☐ High Blood Pressure
☐ Stroke
☐ Congestive Heart Failure

Head / ENT
☐ Migraines
☐ Sinusitis
☐ Dizziness / Vertigo
☐ Chronic Cough

Endocrine
☐ Diabetes
☐ Thyroid Imbalance
☐ Gout
☐ Renal Disease

Integumentary
☐ Acne Rosacea
☐ Lupus
☐ Psoriasis

Hematolgic / Lymphatic
☐ Leukemia
☐ Temporal Arteritis
☐ Lymphatic Disorder
☐ Sickle Cell Disease

Respiratory
☐ Asthma
☐ COPD
☐ Lung Cancer
☐ Lung Disorder

Gastrointestinal
☐ Cancer: Colon, Liver
☐ Colitis
☐ Hepatitis
☐ Irritable Bowel

Genitourinary
☐ Menopause
☐ Prostate Cancer
☐ Cervical Cancer
☐ Breast Cancer

Neurological
☐ Bell's Palsy
☐ Multiple Sclerosis
☐ Parkinson's Disease
☐ Seizures
☐ Brain Tumor

Immunological
☐ AIDS
☐ Sarcoidosis
☐ Sjogren's Syndrome
☐ Syphilis
☐ Tuberculosis

Mental
☐ Alzheimer's
☐ Bi-Polar Disorder
☐ Learning Disability
☐ Depression
☐ Schizophrenia

Musculoskeletal
☐ Arthritis
☐ Rheumatoid Arthritis
☐ Muscular Dystrophy

Height _____ **Weight** _____ **Blood Pressure** _____

Current Medications

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

Current Primary Care Physician _____ **Last Visit** _____

Current Specialty Care Physician _____ **Last Visit** _____

Social Habits:

Alcohol Use	☐ None	☐ Infrequent	☐ Frequent	☐ Daily	☐ Dependence	☐ Decline to report
Tobacco Use	☐ None	☐ Infrequent	☐ Frequent	☐ Daily	☐ Dependence	☐ Decline to report
Narcotic Use	☐ None	☐ Infrequent	☐ Frequent	☐ Daily	☐ Dependence	☐ Decline to report

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Southwest Vision make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

PLEASE **CHECK ONLY THE ONE BOX** THAT APPLIES TO YOU

- ☐ I have read or had explained to me Southwest Vision's Notice of Privacy Practice and agree to continue my care with Southwest Vision under said terms.

- ☐ I have read or had explained to me Southwest Vision's Notice of Privacy Practice and do not wish to continue my care with Southwest Vision under said terms.

- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

  _____

  _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship:

_____ _____

Representative Relationship to Patient

In addition, HIPAA requires the patient's prior authorization in order to release medical information to another person. This includes, but is not limited to, medical records, glasses or contact lenses prescriptions, receipts, or any other documents with personal patient information.

Please list below the person or persons you are allowing access to your medical records and personal information:

_____ _____

_____ _____