Welcome to Halsted Eye Boutique

We are pleased to welcome you to our practice. Your vision and general health is our priority.
Please take a few minutes to fill out our ONE TIME ONLY history form to the best of your knowledge. If you have questions, we will be glad to assist you.

Patient Information

Last Name _____ First _____

❒ Mr. ❒ Mrs. ❒ Ms. ❒ Miss ❒ Dr. How may we address you? _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____

Phone (Work) _____

Phone (Cell) _____

Email _____

Sex ❒ M ❒ F Age _____ Birth date _____

Martial Status: ❒ Single ❒ Married ❒ Domestic Partner ❒ Widowed

Your SS# (for insurance purposes) _____

Occupation _____

Employer _____

In case of emergency, contact _____

Relationship _____

Phone _____

Last Eye Exam _____ / ____ / _____ Dr. _____

Phone _____ City _____ State _____

Last Dilated Exam _____ / _____ / _____Result (circle): Normal / Abnormal / Unknown

How did you hear about us? (please circle all that apply)

Friend / YELP / ZocDoc / Google / Insurance / Revia Magazine / Live in neighborhood

Whom may we thank for referring you? _____

Responsible Party/ Insurance Information

Name of the **Primary Insurance holder**_____

Address: _____

Sex: ❒ Male ❒ Female Relationship to the Patient _____

Date of Birth _____SS# _____

Employer: _____

VISION Insurance Company _____

Policy / ID _____

MEDICAL Insurance Company _____

Policy /ID /Group # _____

If patient is a MINOR, name of PARENT or GUARDIAN _____

Relationship to the Patient _____

Phone #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents have insurance coverage with _____ and assign directly to all insurance benefits, if any, otherwise payable to me for services/materials rendered. I understand that although Halsted Eye Boutique does their best to help obtain maximum benefits, it is ultimately my responsibility to know my individual insurance plan and what it covers.

I authorize release my signature and any information necessary to process insurance claims. I understand that I am responsible for payment of non-covered services, amounts applied toward my deductible, as well as co-insurance amounts. If my account should become past due and collection efforts become necessary, I understand that I will be held responsible for all collection fees.

_____
PRINT NAME of Patient, Parent, Guardian or Personal Representative

_____
SIGNATURE of Patient, Parent, Guardian or Personal Representative

Date _____ / _____ / _____

Eye / Vision Concerns

Primary reason for Today's Visit: _____

_____

Please place a "√" in the ❒ to indicate if you are **experiencing** or **concerned about** any of the following:

- ❒ Blurred Vision – Distance
- ❒ Blurred Vision – Near / Middle
- ❒ Burning Eyes
- ❒ Cataracts
- ❒ Crossed Eyes
- ❒ Crusty Eyelids
- ❒ Discharge from Eyes
- ❒ Dizzy Spells
- ❒ Double Vision
- ❒ Dry Eyes
- ❒ EYE Infection(s)
- ❒ Eye Injury
- ❒ Eye Pain or Soreness
- ❒ Eye Strain
- ❒ Fainting Spells, Blackouts
- ❒ Flashes of light
- ❒ Floaters or Spots
- ❒ Fluctuating Vision
- ❒ Glaucoma
- ❒ Headaches
- ❒ Itching Eyes
- ❒ LID infection(s)
- ❒ Light Sensitivity / Glare
- ❒ Loss of Vision
- ❒ Macular Degeneration
- ❒ Migraines
- ❒ Poor Night Vision
- ❒ Red Eyes
- ❒ Sandy / Gritty feeling
- ❒ Seeing Halos
- ❒ Styes
- ❒ Temporary Loss of Vision
- ❒ Tired Eyes
- ❒ Twitching Eyelid
- ❒ Watering / Tearing Eyes
- ❒ Other _____

Please share with us **any details** regarding the condition(s) you noted above

_____

_____

Contact Lens & Eye Glass History

Other Reason(s) for Today's Visit _____

_____

Do you currently wear **glasses**? ❒ Yes ❒ No Last updated (year)_____

❒ All the time ❒ Occasionally ❒ Occupational glasses
❒ Distance tasks ❒ Near Tasks ❒ Secondary pair for the computer

Do you currently wear **SUN glasses**? ❒ Yes ❒ No Last updated (year)_____

Are they PRESCRIPTION? _____

How many hours do you use the **computer** per day: _____

Have you ever worn **contact lenses**? ❒ Yes ❒ No

Do you currently wear contact lenses, and wish to continue? ❒ Yes ❒ No

Type of Contacts ❒ Disposable ❒ Toric / Astigmatism ❒ Overnight ❒ Gas Perm

What **brand** of contact lenses do you currently wear? _____

You put on **FRESH** contact lenses (circle choice below that applies)

Every _____ days / When they feel uncomfortable or rip / When you remember it's time

Contact Lens **solution brand**_____

How often do you **REPLACE** the **solution** in the contact lens case? _____

Typically, at **what time** do you **insert** the lenses _____AM? **Remove** them at_____PM?

How old is the contact lens **currently in your eyes**? Right _____ Left _____

Do you **sleep / nap** in your contact lenses? ❒ No ❒ Yes How often? _____

IS THERE **ANYTHING** THAT YOU WISH WAS **BETTER** ABOUT YOUR CONTACTS?

_____

Would you like to learn about **LASIK** or non-surgical corneal reshaping? ❒ Yes ❒ No

CONTINUE TO OTHER SIDE → → →

HEALTH HISTORY

When was your last **Physical** Exam_____ Physician's name _____

Address _____ Phone # _____

Please place a "√" in any ❒ to indicate if **YOU** have had any of the following. Also, place a "√" in any ❒ to indicate if a **BLOOD RELATIVE** has had any of the following medical conditions (including parents, grandparents, aunts, uncle, or siblings).

	Yourself (How Long)	**Family Members** (**P**)aternal / (**M**)aternal (Specify which family member & How Long)		
ADHD	❒_____	❒ _____	P	M
AIDS/HIV	❒_____	❒ _____	P	M
Anemia	❒_____	❒ _____	P	M
Anxiety	❒_____	❒ _____	P	M
Arthritis	❒_____	❒ _____	P	M
Asthma	❒_____	❒ _____	P	M
Autism	❒_____	❒ _____	P	M
Blindness	❒_____	❒ _____	P	M
Brain Tumor	❒_____	❒ _____	P	M
Cancer Type_____	❒_____	❒ _____	P	M
Cataracts	❒_____	❒ _____	P	M
Chemical Dependency	❒_____	❒ _____	P	M
Chronic Bronchitis	❒_____	❒ _____	P	M
Constipation	❒_____	❒ _____	P	M
Depression	❒_____	❒ _____	P	M
Diabetes	❒_____	❒ _____	P	M
Diarrhea	❒_____	❒ _____	P	M
Drug Sensitivity (list below)	❒_____	❒ _____	P	M
Dry mouth / throat	❒_____	❒ _____	P	M
Emphysema	❒_____	❒ _____	P	M
Epilepsy	❒_____	❒ _____	P	M
Eye Infections / Ulcers	❒_____	❒ _____	P	M
Eye Surgery	❒_____	❒ _____	P	M
Glaucoma	❒_____	❒ _____	P	M
Glaucoma Suspect	❒_____	❒ _____	P	M
Graves Disease	❒_____	❒ _____	P	M
Gonorrhea (present / history)	❒_____	❒ _____	P	M
Hay Fever	❒_____	❒ _____	P	M
Head Injury	❒_____	❒ _____	P	M
Headaches	❒_____	❒ _____	P	M
Heart Condition	❒_____	❒ _____	P	M
Hepatitis Type _____	❒_____	❒ _____	P	M
Herpes (oral / genital)	❒_____	❒ _____	P	M
High Blood Pressure	❒_____	❒ _____	P	M

	Yourself (How long)	**Family Members** (**P**)aternal / (**M**)aternal (Specify which family member & How Long)		
High Cholesterol	❒_____	❒ _____	P	M
Kidney Disease / Stones	❒_____	❒ _____	P	M
LASIK	❒_____	❒ _____	P	M
Lazy Eye or Turned Eye	❒_____	❒ _____	P	M
Lupus	❒_____	❒ _____	P	M
Macular Degeneration	❒_____	❒ _____	P	M
Migraines	❒_____	❒ _____	P	M
Multiple Sclerosis	❒_____	❒ _____	P	M
Myasthenia Gravis	❒_____	❒ _____	P	M
Pacemaker	❒_____	❒ _____	P	M
Retinal Detachment	❒_____	❒ _____	P	M
Seizures	❒_____	❒ _____	P	M
Sickle Cell	❒_____	❒ _____	P	M
Shingles	❒_____	❒ _____	P	M
Sjorgen's Syndrome	❒_____	❒ _____	P	M
Skin Disorder	❒_____	❒ _____	P	M
Sleep Apnea	❒_____	❒ _____	P	M
Thyroid Condition	❒_____	❒ _____	P	M
Ulcers	❒_____	❒ _____	P	M
Vision Training / Patching	❒_____	❒ _____	P	M

Other not listed _____

Are you pregnant or nursing? ❒ Yes ❒ No Number of children _____

SOCIAL HISTORY

Do you **DRIVE**? ❒ No ❒ Yes ❒ Occasionally ❒ Rarely

Do you SLEEP with your eyes a bit **OPEN**? ❒ Don't know ❒Yes, I've been told I do

Do you **SNORE**? ❒ No ❒ Occasionally ❒ Yes

Do you currently use **tobacco**? ❒ No ❒ Occasional ❒ ½ pack/day ❒ pack+

❒ History of use for _____ years, and quit _____ months / years ago

Do you use **alcohol**? If yes, how much? ❒ No ❒ Social ❒ 1/day ❒ 2-3/day

Do you use illegal / recreational **drugs**? ❒ No ❒ Yes, how often?_____

Sports & **Hobbies**: _____

Medications / Vitamins / Supplements (including oral contraceptives, over-the-counter medications, and eye drops)_____

_____

ALLERGIES

Please place a "√" in any ❒ to indicate if you have any sensitivities or allergies in the categories below.

- ❒ **Contact Lens Solutions** (list) _____
- ❒ **Drugs** (List) _____
- ❒ **Foods** (List) _____
- ❒ **Environmental** / **Seasonal** (Please indicate **when**) _____