Hess Optometric Associates

Gary R. Hess, O.D. *hesseyecare.com*

Medical History

Name _____ SS#_XXXX_-_XX_-_____ Date _____/_____/_____

Address _____ Phone: _____

City _____ State _____ Zip Code _____ Cell: _____

Date of Birth ____/____/_____ Gender: Male/ Female Email: _____

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Employer/ Occupation: _____ Work Phone: _____

City _____ State _____

If a student, name of school / college / year _____

Whom may we thank for referring you? _____

Primary Care Physician: _____ Location: _____ Last Visit: _____

Do you currently wear glasses? ❑ Yes ❑ No If Yes, ❑ Single Vision ❑ Bifocals ❑ Magnifiers ❑ Progressive lenses ❑ Safety ❑ Sports

Do you wear contact lenses? ❑ Yes ❑ No If yes, what type of contacts_____

Reason for today's appointment: _____ Last Eye Exam _____

Are you interested in (check all that apply): ❑ eyeglasses ❑ contact lenses ❑ laser vision correction

In case of Emergency contact: _____ Phone: _____

Review of Systemic Health: Please check any problems **you** are currently having or you have had recent problems with:

Systemic Health	Yes	No		Yes	No
Endocrine Problems (Thyroid Disease)			Musculoskeletal Problems (Arthritis, joint pain)		
Respiratory (Shortness of breath, cough, etc.)			Neurological (Numbness, weakness, paralysis)		
Heart (chest pain, irregular heartbeat)			Psychiatric Problems (Depression, anxiety)		
Ears, Nose, Throat (hearing loss, **Sinus** or sore throat)			Urinary Tract (Pain, discomfort, bowel movements)		
Chronic fever, weight gain, weight loss			Digestion Problems/ Abdominal Pain		
Hematologic/Lymphatic (Anemia, Breast cancer)			Genitourinary (Prostate or Ovarian cancer)		

Systemic Health	Yes	No	Please Circle, if yes	Diagnosis date, Last reading
Diabetes			Controlled, Fluctuating, Uncontrolled	/ /
High Blood Pressure			Controlled, Fluctuating, Uncontrolled	/ /
Cholesterol			Controlled, Fluctuating, Uncontrolled	/ /

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

EYE HISTORY	Yes	No		Yes	No		Yes	No
Sandy or Gritty			Glaucoma			Loss of Side Vision		
Itching			Cataracts			Double Vision		
Burning			Macular Degeneration			Dryness		
Foreign Body Sensation			Fluctuating Vision			Mucous Discharge		
Excess Tearing			Drooping Eyelid			Redness		
Glare/ Light Sensitivity			Flashes of Light			Lazy / Crossed Eye		
Pain or Soreness			Floaters or Spots			Poor Night Vision		
Loss of Vision			Blurred Vision with Glasses			Color Blindness		
Blurred Distance Vision			Blurred Near Vision			Eye Infections		
History of Eye Surgery			Headaches			Other		

Family History	Yes	No	*If yes,relationship to you?*
Amblyopia (Lazy Eye)			
Glaucoma			
Retinal Detachment			
Macular Degeneration			
Blindness or Vision Loss			

Social History, Do you	Yes	No	How much/ often
Use alcohol?			
Use tobacco products?			
Use narcotics?			

***All information is kept strictly confidential.*

Medications: _____

_____

_____

_____

Current Eye Drops or Eye Vitamins: _____

Allergies: Medications and Seasonal: _____

_____

AUTHORIZATION & RELEASE

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

●X_____ Date_____/_____/_____ Gary R Hess ____

■ X_____ Date_____/_____/_____ Gary R Hess ____

♦ X_____ Date_____/_____/_____ Gary R Hess ____