SIRI PREMIER EYECARE
See Good • Look Good • Feel Good

Patient History Form

724 Cambridge Marketplace Blvd
Cambridge MD 21613
443-225-5377

Date of Visit: ____________________ **Email Address:** ____________________

Last Name: ____________________ **First Name:** ____________________ Last 4-digits **SSN**: __________

Home Phone: ____________________ **Work Phone:** ____________________ **Mobile:** ____________________

Employer: ______________ **Occupation:** ______________ **DOB:** ______________ **Age:** __________

INSURANCE

Primary Insurance: ____________________

Primary Insurer's Name: ____________________

How did you hear about us? *(Circle all that apply)*
Family / Friend / Google / Social Media / Doctor

Need *(Circle all that apply)* **:** Glasses / Contact Lenses / Other: ____________________

Symptoms *(Circle all that apply)* **:** Blurry vision / Flashes / Floaters / Red eye / Pain / Double vision

How many hours do you spend on the computer per day? ____________________

At the end of the day *(Circle all that apply)* **:** My eyes feel tired / I have headaches / My eyes feel dry

My eyes feel *(Circle all that apply)* **:** Dry / Heavy / Gritty / Red **When?** Always / Start of day / End of day

PERSONAL OCULAR HISTORY: (Check all that apply)

( ) Wears glasses

( ) Wears contact lenses

( ) Lazy eye

( ) Eye Surgery

( ) Eye Trauma / Injury

( ) Cataract

( ) Macular degeneration

( ) Glaucoma

( ) Blindness

Other: ____________________

PERSONAL MEDICAL HISTORY: (Check all that apply)

( ) Diabetes: Last A1C ______________%

Last blood sugar ______________ mg/dL

Last Dr.'s appointment: ____________________

( ) High Blood Pressure **( )** High Cholesterol

( ) Thyroid Disease

( ) Autoimmune disease: Rosacea / Lupus / Lyme disease / Rheumatoid Arthritis / Crohn's disease

Other: ____________________

( ) Heart Disease **( )** Stroke: Date ______________

( ) Cancer: Type/s ____________________

Year Diagnosed: ______________ In Remission: Y **( )** N **( )**

( ) HIV / AIDS: CD-4 Count __________ Viral load: __________

FAMILY OCULAR HISTORY: (Check all that apply)

( ) Lazy eye: Who? ____________________

( ) Cataracts: Who? ____________________

( ) Macular degeneration: Who? ____________________

( ) Glaucoma: Who? ____________________

( ) Blindness: Who? ____________________

Other: ____________________

FAMILY MEDICAL HISTORY: (Check all that apply)

( ) Diabetes: Who? ____________________

( ) High blood pressure: Who? ____________________

( ) Stroke: Who? ____________________

( ) Cancer: Type/s ____________________

Who? ____________________

PLEASE PROCEED TO THE NEXT PAGE

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SOCIAL HISTORY: (Circle all that apply)

Non-smoker? **YES / NO**
Current smoker? **YES / NO** 1/2 pack / day 1 pack/day >1 pack a day
Former smoker? **YES**
Do you drink? **YES / NO** How much? ___________________________

CURRENT MEDICATIONS: ____

____

CURRENT DOCTORS: ____

ALLERGIES / REACTION TO MEDICATION/S: YES / NO
If YES, which medication/s and what type of reaction? ____

ARE YOU PREGNANT? YES / NO
If YES, how many months? ________________________

** All professional fees / copays are due at the time of service.* **NO REFUNDS. STORE CREDIT ONLY.** ***
** No show fee of $140 **

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my optometrist named above to release health information identifying me [including if applicable, my eyeglass/ contact lens prescriptions, information about my ocular health, HIV/AIDs, substance abuse treatment and my mental health] under the following terms and conditions:

1. Detailed description of the information released:
2. To whom may the information be released [name (s) or class (es) of recipients]:
3. The purpose (s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as a purpose, if desired by the individual):
4. Expiration date of the event relating to the individual or purpose for the release:
It is completely your decision whether to sign this authorization form or not. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send the note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND I UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient/Legal Guardian Signature:	Date of Signature:	Relationship to Patient:

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