John C. Hersey, OD

Virginia L. Gilmore, OD

www.HerseyEyeCare.com

Reset / Clear

Date:	General Information	Chart #:

*** The information in this confidential personal history will be protected according to HIPPA requirements. ****

Name: *(Last)*	*(First)*	*(M.I.)*

Aliases:

Date of Birth:	Age:	Gender: ☐ Male ☐ Female	S.S. #:

Address *(Mailing)*:

City:	State:	Zip:

Phone *(Home)*:	*(Cell)*	E-mail:

Employer:	Phone:	Ext.

Occupation:

Insurance Information

*** Please give receptionist your insurance card so we can make a copy. ****

Do you have insurance? ☐ Yes ☐ No	Insurance Provider:
Is the insurance in your name? ☐ Yes ☐ No	If NO, relationship to insured?
Does Your Insurance cover Routine Eye Exams? ☐ Yes ☐ No	How often? ☐Yearly ☐ Every 2 Years

NOTE: If a referral is needed, it is your responsibility to get the proper referral from your primary care provider.

Emergency Contact Information

*** In case of an emergency, whom should we notify? ****

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

General Questions

What vision improvement(s) are you interested in? ☐ Glasses ☐ Contact Lenses ☐ Laser Correction

*** Contact Lens Evaluation and Fittings may not be covered by insurance and are the responsibility of the patient. ****

What is your main reason for coming in today?

☐ Poor Distance Vision	☐ Poor Near Vision	☐ Dry Eyes	☐ Headache	☐ Itching
☐ Bloodshot Eyes	☐ Burning Eyes	☐ Watering	☐ Eye Strain	☐ Twitching Eyelid
☐ Flashes of Light	☐ New Floaters	☐ Infection	☐ Injury	☐ Poor Night Vision

☐ Other:

Date of your last eye exam?	By whom?

Do you wear glasses? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Have you worn contact lenses in the past? ☐ Yes ☐ No

If YES, what brand? **What power?**

Replacement plan? ☐ Daily ☐ 2 Weeks ☐ Monthly ☐ 3 Months

What activities do you do? ☐ Other:

☐ Driving	☐ Typing	☐ Computers	☐ Inspecting
☐ Writing/Editing	☐ Deliveries	☐ Sales	☐ Monitor Instruments

When using a computer, do your eyes get? ☐ Red ☐ Dry ☐ Itchy ☐ Sore

Do you avoid certain visual tasks? ☐ Yes ☐ No **If YES, what?**

Physician's Name: **Office Name:**

Medication & Allergy Information

Please list all medication: ☐ **None**

Medical allergies? ☐ **None**

Health History

***** Please check all that apply. *****

Height: **Weight:**

Your Medical History

General

Diabetes	☐ Yes ☐ No
• Date of diagnosis:	
• Last A1C (blood test):	
• Last sugar reading:	
High Blood Pressure	☐ Yes ☐ No
Heart Problem	☐ Yes ☐ No
Asthma / Bronchitis	☐ Yes ☐ No
Pregnant / Lactating	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Type:
Do you smoke? ☐ Yes ☐ No	Amt:
History of smoking? ☐ Yes ☐ No	Amt:
Do you drink? ☐ Yes ☐ No	Amt:

Family Medical History

General

Cancer	☐ Yes ☐ No	☐ Parents ☐ Siblings
Diabetes	☐ Yes ☐ No	☐ Parents ☐ Siblings
Heart Problems	☐ Yes ☐ No	☐ Parents ☐ Siblings
Blood Pressure	☐ Yes ☐ No	☐ Parents ☐ Siblings
Other:		

Ocular

Lazy Eye	☐ Yes ☐ No	☐ Parents ☐ Siblings
Retinal Problems	☐ Yes ☐ No	☐ Parents ☐ Siblings
Glaucoma	☐ Yes ☐ No	☐ Parents ☐ Siblings
Blindness	☐ Yes ☐ No	☐ Parents ☐ Siblings
Cataracts	☐ Yes ☐ No	☐ Parents ☐ Siblings
Macular Degen.	☐ Yes ☐ No	☐ Parents ☐ Siblings
Other:		

Ocular (Self)

Glaucoma	☐ Yes ☐ No	**Lazy Eye**	☐ Yes ☐ No	**Cataracts**	☐ Yes ☐ No
Dry Eye	☐ Yes ☐ No	**Eye Infection**	☐ Yes ☐ No	**Retinal Problems**	☐ Yes ☐ No
Eye Injury	☐ Yes ☐ No	What:			
Eye Surgery	☐ Yes ☐ No	What:			

Other medical conditions? (Please list)

Who may we thank for referring you to our office?

Name of friend or relative:

If not referred, how did you choose our office?

☐ **Wal*Mart Optical** ☐ **Lens Crafters**

☐ **Other** *(Enter below)* ☐ **Insurance** ☐ **Saw Sign** ☐ **Dr.** _____

Patient Responsibility

Office policy calls for payment at the time of service. We accept cash, check, debit, and credit card. You are responsible for fees not covered by your insurance. I confirm that the above information is accurate to the best of my knowledge. I have also had a chance to review the **Notice of Privacy Practices**.

Patient Signature **Date Signed**