Patient Health History

Demographic/Contact Information

Patient Name: _____ **Date of Birth:** _____

Preferred Name*: _____ **Gender:** _____

Gender Identity* (If different from above): _____

Mailing Address: _____

Primary Phone: _____ **Secondary Phone:** _____ **Email:** _____

Emergency Contact Name: _____ **Phone:** _____

Occupation: _____ **Employer:** _____

Race/Ethnicity (Circle One): American Indian or Alaska Native • Asian • Black or African American

Native Hawaiian or Other Pacific Islander • White: Not Hispanic or Latino • White: Hispanic or Latino

Primary Language: English • French • Spanish • Other (Please specify)_____

*EyeCare of Vermont is committed to maintaining a positive, caring, and respectful environment for its patients and staff. We will do our best to use your preferred name and/or pronouns during your time in the office. For filing and billing purposes we are required to use the name that appears on your insurance card.

Please check any current or past conditions that apply to you

	Hematologic		**Ear, Nose, & Throat**		**Allergies**		**Cancer/Oncology**
	Anemia		Sinusitis		Environmental		Type_____
	Leukemia		Respiratory Infection		Latex		Current / Remission
	Bleeding Disorder		Hearing Loss		Other_____		**Endocrine/Glands**
	Other_____		Other_____		**Cardiovascular**		Hormone Dysfunction
	Immunologic		**Gastrointestinal**		High Blood Pressure		Thyroid Dysfunction
	Lupus		Crohn's Disease		Heart Disease		Other_____
	Rheumatoid Arthritis		Colitis		Stroke		**General Health**
	HIV Positive		Acid Reflux/Ulcers		Vascular Disease		Height_____'_____"
	Hepatitis		Other_____		High Cholesterol		Weight_____
	Other_____		**Psychiatric**		Other_____		Weight Change?
	Neurological		Depression		**Muscular/Skeletal**		Tobacco: Current User
	Multiple Sclerosis		Bipolar Disorder		Arthritis		Tobacco: Former User
	Epilepsy		Schizophrenia		Fibromyalgia		Alcohol Consumption
	Tremors		Other_____		Ankylosing Spondylitis		Drinks/Week_____
	Migraines		**Skin**		Other_____		Recreational Drugs
	Memory Loss		Eczema		**Respiratory**		Other_____
	Brain Injury		Rosacea		Asthma		**Genital/Urinary**
	Developmental		Psoriasis		Bronchitis		U. Tract Infections
	Other_____		Shingles		Emphysema		Herpes/Chlamydia
			Other_____		Other_____		Other_____

Please indicate if any of the following currently apply to you

Wearing Full-Time Glasses	Yes / No	If Yes:	Circle One: Distance / Multifocal / Readers
Wearing Full-Time Contacts	Yes / No	If Yes:	Circle One: Distance / Multifocal
Taking Rx Plaquenil	Yes / No	If Yes:	Timeline/History: _____
Taking Rx Tamoxifen	Yes / No	If Yes:	Timeline/History: _____
Pregnant or Nursing	Yes / No	If Yes:	Timeline/History: _____

Please indicate if you or a blood relative have a history of the following conditions

Condition	Self	Family	Relationship (if family member)
Retinal Detachment			
Blindness			
Cataracts			
Eye Turn			
Glaucoma			
Macular Degeneration			
Diabetic/Pre-Diabetic (Circle: Type 1 or 2)			

Medical History

Primary Care Physician: _____ **Date of Last Exam:** _____

List any other doctors involved in your eye care: _____

_____

List any current medications including over-the-counter, vitamins, and herbal therapy: _____

_____

_____

List all major surgeries, including eye surgery: _____

_____

List any allergies to medications or eye drops: _____

_____

Please list any accommodations you may require while visiting our office (Wheelchair accessible exam rooms, language interpreters, etc.): _____

Please sign below to acknowledge that you have completed this form to the best of your knowledge, and that you have received a copy of Eyecare of Vermont's HIPAA Notice of Privacy Practices.

Signature: _____ **Date:** _____