Family Eye Care of Shawnee, PLLC
Drs. Hoster & Ewert - Optometrists
2109 N. Kickapoo, Shawnee Ok, 74804
(405) 275-2020

Patient Information with Medical History

Important: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name_____________________First Name_____________________MI ____Birth date: ___/___/___Today's Date ___/___/___
Address_____________________________City___________________________ State _____ Zip ________ Age/Sex ____/____
Work phone (_____) ____-______________ Home phone (_____) ____-______________ Cell phone (_____) ____-____________
Email _________________________ SSN _____-_____-_____ Employer: ___________________________
Insurance: (Circle One) Medicare DHS VSP ECPA PVCS Other Insurance ID: ________________________
Primary Insured Name ____________________ Primary's DOB ____/____/____ Primary's Employer _____________________
Emergency contact name (parent/spouse/other) _______________________ Phone (_____) ____-______________
Parent/Guardian Name: ___________________________ Birth Date: ______________ SSN: _______________________
Referred By: ___________________________________

I have read the HIPPA privacy rule and was offered a copy. _______________________ ____________________
Patient Signature **Date**

Authorization for Release of Identifying Health Information
I, _________________, authorize Family Eye Care of Shawnee, PLLC, to release health information identifying the patient/myself to (Name) _________________, (Relationship to Patient) ________________. I acknowledge that I am responsible for any fees and expenses incurred in Drs. Hoster's and Ewert's Office. I know I am personally responsible for any fees not paid by third party plans.
(Payment Is Due At The Time Of Service)
Patient/Guardian Name: ______________________ **Signature:** _____________________________

Patient/Parent/Guardian Signature authorizes release of any information acquired in the course of my examination or treatment:
Signature: _______________________________________

MEDICAL HISTORY (Please complete form front and back.)

Allergies to Medications? Yes/No Which? ________________________________ Reactions? ___________________
Current Medication(s): Yes/No Please list: ____
Date of last Tetanus shot? ________________________________

Have you had any operations? Yes/No What Kind? ____

Name of Family Doctor or Primary Care Physician: ___________________________ **Date of last visit:** _____________

Family History:
Please note any family history (parents, grandparents {maternal/paternal}, siblings, children; living or deceased) for the following conditions:

Condition	Yes/No	Relation
High blood pressure	Yes/No	Relation ______________________________
Diabetes	Yes/No	Relation ______________________________
Cancer, type _______	Yes/No	Relation ______________________________
Thyroid disease	Yes/No	Relation ______________________________
Heart Disease	Yes/No	Relation ______________________________
Glaucoma	Yes/No	Relation ______________________________
Macular Degeneration	Yes/No	Relation ______________________________
Retinal Detachment	Yes/No	Relation ______________________________
Cataracts	Yes/No	Relation ______________________________
Blindness	Yes/No	Relation ______________________________
Other _____________	Yes/No	Relation ______________________________

Social History:
Tobacco: Yes/No **Smokeless Tobacco (vapors, dip/chew):** Yes/No **Former Smoker**: Yes/No
Alcohol: Yes/No **If yes**, do you use socially, daily, weekly, or dependent? (Please circle one).
Illicit Drugs: Yes/No
Do you drive? Yes/No **If yes, do you have visual difficulty when driving?** Yes/No **If yes, please explain:** ___________
____

Please turn this form over and complete side two

What is your general health? ______________________________

Review of Systems: Do you currently, or have you ever had any problems with the following systems? (Please circle yes or no)

Constitutional

Unintentional Fever, Weight Loss/Gain	Yes/No

Ears/Nose/Throat

Allergic Rhinitis/Hay Fever	Yes/No
Sinus Congestion	Yes/No
Chronic Cough	Yes/No
Hearing Impaired	Yes/No

Cardiovascular/Vascular

Myocardial Infarction	Yes/No
Congestive Heart Failure	Yes/No
Hypertension (High Blood Pressure)	Yes/No
Vascular Disease	Yes/No

Respiratory

Asthma	Yes/No
Chronic Bronchitis	Yes/No
Emphysema/COPD	Yes/No

Neurological

Headaches/Migraines	Yes/No
Seizures/Epilepsy	Yes/No
Stroke/TIA	Yes/No
Parkinson's/Tremors	Yes/No

Lymphatic/Hematologic (blood)

Anemia	Yes/No
Bleeding Problems	Yes/No
Anticoagulation Therapy	Yes/No

Endocrine (glands)

Thyroid	Yes/No
Diabetes, Type ___________	Yes/No
Other glands	Yes/No

Gastrointestinal

Diarrhea (Chronic)	Yes/No
Constipation (Chronic)	Yes/No
Acid Reflux/GERD	Yes/No
High Cholesterol/Lipids	Yes/No
IBS	Yes/No

Genitourinary

Genitals	Yes/No
Bladder	Yes/No
Kidneys	Yes/No

Bones/Joints/Muscles

Rheumatoid Arthritis	Yes/No
Muscle/Joint Pain	Yes/No
Fibromyalgia	Yes/No
Lupus	Yes/No

Integumentary (skin)

Eczema	Yes/No
Psoriasis	Yes/No

Allergic/Immunologic

Allergies	Yes/No
Anaphylaxis	Yes/No
Autoimmune Disease	Yes/No

Psychiatric/Mental Disorders

Depression	Yes/No
ADHD/ADD	Yes/No
Mood Disorders	Yes/No
Anxiety	Yes/No
Bipolar Disorder	Yes/No

If you have a condition not listed, please explain.

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Personal Eye Information:

Date of last eye exam _____/_____/_____

Do you have any eye conditions or problems? Yes/No If yes, what kind? ______________________

Have you had any eye operations? Yes/No Type? ______________________ Date? ___________

Have you had an eye injury? Yes/No Kind? ______________________ Date? ___________

Do you have any of the following?

Cataracts	Yes/No	Glaucoma	Yes/No
Macular Degeneration	Yes/No	Retinal Detachment	Yes/No
Dry Eyes	Yes/No	Blurred Vision	Yes/No

Do you wear glasses? Yes/No

Do you wear contact lenses? Yes/No If yes, what type? ______________________

Additional Information: ______________________

Doctor Use Only

Reviewed by ______________________ Reviewed by ______________________

Reviewed by ______________________ Reviewed by ______________________

Reviewed by ______________________ Reviewed by ______________________