Updated History Form

Name: _____ **Date of Birth**:_____/_____/_____

Email Address:_____

Primary Care Physician:_____

Note: **This information will become part of your medical record. All information contained in it will be held in the strictest of confidence per federal privacy regulations.**

Please describe any new problems you feel have occurred with your eyes since your last visit to our office:

_____
_____
_____
_____If none, please circle NONE

Since your last visit to our office, have you had any: eye injury, eye surgery, eye infections or dryness in your eyes? If yes, please circle it and describe below.

_____
_____
_____
_____If none, please circle NONE

Do you now or have you ever had any of the following (please circle all that apply):

High blood pressure, Heart attack, Angina, Irregular heartbeat, any other vascular problems ……. NONE

Asthma, Pneumonia or any other breathing or lung problems ……..NONE

Diabetes, Thyroid disease or any other endocrine (glandular) problems ……..NONE

Migraine, Stroke, Seizures, serious headaches or other neurological problems ……NONE

Skin cancer or suspicious skin lesions that are being followed by a doctor……NONE

Cancer of any kind. Type or location: _____……..NONE

Do you have any disease, condition or other medical problem that is not listed above? If so, please describe:

_____ NONE

Over ->

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What is your occupation? _____

Do you smoke? YES NO Have you ever been a smoker? YES NO If yes, when did you quit? _____

Please list all medications (Rx and OTC) that you are currently taking or provide a list that we can photocopy or circle if applicable, circle: NO CHANGES

_____
_____
_____
_____
_____If none, please circle…….NONE

Are you allergic to any medications? If yes, please list:

_____
_____If none, please circle……NONE

Is there any family history in parents and/or siblings of any of the following eye conditions, if yes who?

Macular Degeneration:_____ Cataracts:_____

Glaucoma, Suspicion of Glaucoma, High pressure in the eyes: _____

Retinal detachment or Retinal Tear:_____

Authorization to bill your insurance: By signing below, I authorize MacKay Vision Center, LLC to bill my insurance company for all services rendered to me or my dependent child. I understand that my insurance provider may pay less than, or none of the actual bill for services depending on my deductible. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my child.

Signature:_____ Date:____/_____/_____

Thank-you for taking the time to update your health information. Please return this form to the reception desk.