Harron Eye Care

Dr. Andrea Harron OD Dr. Sean Harron OD

Date _____/_____/_____

Name: _____

Mailing Address: _____ APT/LOT _____

City / State _____ Zip _____

Phone #: ( ) - Home / Mobile

Phone #: ( ) - Home / Mobile

May we leave a voice message for appointment reminders? Y / N

Preferred Method(s) of Communication: ***PLEASE CIRCLE Y or N***

Yearly Letter/Postcard Y / N

Patient Portal Y / N

Email Y / N If yes, write e-mail address below:

_____

Age:_____ DOB: ____/____/_____

SSN: _____-_____-_____ Sex: M / F

Martial Status: Single / Married / Divorced / Widowed

EMPLOYER:_____

DISABLED: Y / N Disability: _____ RETIRED: Y / N

Pharmacy Name: _____

Pharmacy City/State: _____

Medical Insurance Provider: _____

ID#: _____

Vision Insurance Provider: _____

ID#: _____

Primary Care Physician: _____

City/State: _____

Emergency Contact: Name:_____

Phone: _____ Relation: _____

***Reason For Your Visit*:** _____

Past Medical History (Please check all that apply) **_____NONE**

_____ Anxiety
_____Arthritis
_____Asthma
_____Atrial Fibrillation (Irregular Heart Beat)
_____Bone Marrow Transplantation
_____Breast Cancer
_____Colon Cancer
_____COPD
_____Coronary Artery Disease
_____Depression
_____Diabetes (Insulin / Oral) A1C _____
_____End Stage Renal Disease
_____GERD
_____Hearing Loss
_____Hepatitis
_____Hypertension (High Blood Pressure)
_____HIV/AIDS
_____Hypercholesterolemia (High Cholesterol)
_____Hyperthyroidism (Overactive Thyroid)
_____Hypothyroidism (Underactive Thyroid)
_____Leukemia
_____Lung Cancer
_____Lymphoma
_____Currently Pregnant
_____Prostate Cancer
_____Radiation Treatment
_____Seizures
_____Stroke
_____Other: _____

Surgical History: **_____NONE**

_____

_____

Ocular History: **_____NONE**

____Glasses (Prescription / Reading)
____Contact Lenses (Rigid / Soft / Extended Wear / Other)
____Allergic Conjunctivitis
____Cataract (Both / RT / LT)
____Corneal Dystrophy (Both / RT / LT)
____Diabetic Retinopathy (Both / RT / LT)
____Dry Eyes
____Glaucoma (Both / RT / LT)
____Keratoconus
____Macular Degeneration (Both / RT / LT)
____Ophthalmic Migraine
____Retinal Tear (Both / RT / LT)
____Strabismus (Lazy Eye) (Both / RT / LT)
____Other: _____

Ocular Surgery: **_____NONE**

____Blepharoplasty (Both / RT / LT)
____Cataract (Both / RT / LT)
____Corneal Transplant (Both / RT / LT)
____Eye Muscle Surgery (Both / RT / LT)
____Intravitreal Injections (Both / RT / LT)
____Lasik (Both / RT / LT)
____Strabismus Surgery
____Retinal Laster (Both / RT / LT)
____Yag Capsulotomy (Both / RT/ LT)
____Other: _____

Allergies & Reactions to Medicines: **_____NONE**

_____

_____

Medications: ***DO NOT LEAVE BLANK IF YOU TAKE MEDICINE.* ** I brought a medications list Y / N **_____NONE**

_____

_____

Have you received the Flu and/or Pneumonia shot(s) this year? Y_____ / N_____

Social History:

Do you use tobacco products? Y / N If YES please specify: _____ Former Smoker? Y / N

Do you drink alcohol? Y / N If YES please specify: _____ Former Drinker? Y / N

Do you use illegal drugs? Y / N If YES please specify: _____ Former User? Y / N

Do you Drive? Y / N ____Day Time ____Night Time

Review of Systems:

EYES:

___**poor vision** ___itching ___floaters ___eye pain ___burning

___flashes ___tearing ___mattering ___loss of sharpness

___redness ___loss of vision

CONSTITUTIONAL:

___fever ____chills ___weight loss / gain

EARS/NOSE/THROAT/MOUTH:

___stuffy nose ___ear ache ___cough ___dry mouth

CARDIOVASCULAR:

___high blood pressure ___rapid heart beat

RESPIRATORY:

___congestion ___wheezing ___shortness of breath

GASTROINTESTINAL: **_____NONE**

___upset stomach ___diarrhea ___constipation

___burning on urination ___urinary frequency ___incontinence

MUSCULOSKELETAL:

___joint pain ___stiffness

INTEGUMENTARY:

___rash ___changing moles

NEUROLOGICAL:

___headache ___seizure ___stroke ___paralysis

PSYCHIATRIC:

___anxiety ___depression ___insomnia

ENDOCRINE:

___diabetes ___thyroid abnormalities

Hematologic / Lymphatic:

___bleeding ___anemia ___allergies ___hay fever ___hives

Family History: (Only Immediate Family History is necessary)

_____NONE _____UNKNOWN

	Mother	Father	Sister	Brother
Thyroid Disease				
Diabetes				
Hypertension				
Cancer				
Strabismus (Crossed Eye)				
Cataract				
Glaucoma				
Amblyopia (Lazy Eye)				
Severe Myopia (Nearsighted)				
Macular Degeneration				
Severe Hyperopia (farsighted)				
Other: _____				
Other: _____				

AUTHORIZATION: Benefits to Optometrist

____YES ____NO I hereby authorize payments to Walmart & Harron Eye Care

____YES ____NO I understand that I am responsible for any portion of my bill NOT covered by the insurance company

____YES ____NO I authorize the release of information for insurance claims purposes. This information may contain medical information pertaining to communicable or venereal disease including gonorrhea, HIV, and AIDS.

____YES ____NO I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the notice.

Authorize release of your medical records:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

***I certify that the information of this patient information form is correct to the best of my knowledge. I will not hold the doctor or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I give permission to the doctor/staff to administer and perform such procedures as may be deemed necessary in the diagnosis and treatment of my eyes

Patient Signature _____

If Minor, Parent/Guardian Signature _____ Date _____