MEDICAL OPTOMETRY AMERICA

MedODamerica.com

NEW PATIENT MEDICAL & OCULAR HISTORY FORM

Date: ____/____/____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Social Security #: _____ Marital Status: _____ Sex: _____

Date of Birth: _____ Age: _____

Address: _____ Apt./Suite #: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email (for appointment reminders and office news): _____

Occupation: _____ Employer/School: _____

How Did You Hear About Us? _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____ MI: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Relationship to Patient: _____

INSURANCE INFORMATION

If Insurance Policy is held by someone other than you, the patient:

Policy Holder Name: _____ Policy Holder Date of Birth: _____

*Please be sure to provide us with a copy of your medical insurance card

PRIMARY CARE PHYSICIAN and REFERRING PHYSICIAN

Primary Care Physician Name: _____ Phone Number: _____

Referring Physician Name: _____ Phone Number: _____

PHARMACY

Pharmacy Name: _____ Phone: _____

Address: _____ City: _____ State: _____

ACCOUNT FINANCIAL RESPONSIBILITY

❑ Check the box if the patient is financially responsible for this account. Otherwise, list responsible party below:

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt./Suite #: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Date of Birth: _____

Relationship to Patient: _____

OCULAR HISTORY

Please describe any concerns you have regarding your eyes, vision, ocular health, or disease prevention:

_____

_____

Date of Last Eye Exam: _____ Doctor/Location: _____

Do You Currently Use or Wear: Eyeglasses: ❑ No ❑ Yes
Contact Lenses: ❑ No ❑ Yes

Ocular History	Self	Family	Relation		Self	Family	Relation
Lazy Eye	❑	❑	_____	Retinal Detachment	❑	❑	_____
Eye Turn/Wandering	❑	❑	_____	Blindness	❑	❑	_____
Color “Blind”	❑	❑	_____	Cataracts	❑	❑	_____
Light Sensitivity	❑	❑	_____	Glaucoma	❑	❑	_____
Eyestrain	❑	❑	_____	Eye Injury/Surgery	❑	❑	_____
Dry Eyes	❑	❑	_____	Macular Degeneration	❑	❑	_____
Floaters/Spots	❑	❑	_____				

Other History Not Listed: _____

MEDICAL HISTORY

Medical History	Self	Family	Relation
High Blood Pressure	❑	❑	_____
Cholesterol	❑	❑	_____
Diabetes	❑	❑	_____
Thyroid	❑	❑	_____
Arthritis	❑	❑	_____
Gastrointestinal	❑	❑	_____
Medical History	**Self**	**Family**	**Relation**
Respiratory	❑	❑	_____
Cancer	❑	❑	_____
Headaches/Migraines	❑	❑	_____
Head Trauma	❑	❑	_____
Stroke	❑	❑	_____
Neurological Disorder	❑	❑	_____

Please list all medications you are currently taking and why (*e.g.*, Lipitor for cholesterol):

_____

_____

_____

Surgical History:

_____

_____

_____

Are You:

Allergic to Medication: ❑ No ❑ Yes (if yes, please list below)

_____

_____

Pregnant or Nursing: ❑ No ❑ Yes If yes, please list your due date: _____

Being Treated for: ❑ HIV ❑ Hepatitis ❑ Gonorrhea ❑ Syphillis

❑ Other: _____

REVIEW OF SYSTEMS

	No	Yes
CONSTITUTIONAL		
Fever, Weight Loss/Gain	❑	❑
INTEGUMENTARY skin conditions	❑	❑
NEUROLOGICAL		
Headaches/Migraines	❑	❑
Seizures	❑	❑
EYES		
Loss of vision	❑	❑
Blurred vision	❑	❑
Double vision	❑	❑
Dryness	❑	❑
Redness	❑	❑
Itching	❑	❑
Pain	❑	❑
Glare	❑	❑
Flashes/Floaters	❑	❑
ENDOCRINE		
Thyroid/glands	❑	❑
Diabetes/blood sugar	❑	❑
BONES/JOINTS/MUSCLES		
Arthritis	❑	❑
Muscle pain	❑	❑
PSYCHIATRIC	❑	❑

	No	Yes
EAR, NOSE, THROAT		
Allergies/Hay Fever	❑	❑
Sinus/runny nose	❑	❑
Post-Nasal Drip	❑	❑
Dry mouth/throat	❑	❑
RESPIRATORY		
Asthma	❑	❑
Bronchitis/Cough	❑	❑
Emphysema	❑	❑
COPD	❑	❑
VASCULAR/CARDIO		
Vascular disease	❑	❑
High Blood Pressure	❑	❑
Chest Pain	❑	❑
GASTROINTESTINAL		
Diarrhea	❑	❑
Constipation	❑	❑
GENITOURINARY		
Genital/Kidney/Bladder	❑	❑
LYMPHATIC/HEMATOLOGIC		
Anemia	❑	❑
Bleeding/bruising	❑	❑
ALLERGIC/IMMUNE	❑	❑

If you answered YES, please explain and list the condition/symptom:

_____

_____

CONSENT TO TREATMENT:

By signing below, I do hereby voluntarily consent for MOA to provide eyecare services including diagnostic procedures and treatments deemed necessary in the judgment of the optometrist. I acknowledge that no guarantees have been or can be made to me as a result of such procedures and treatments. I also authorize the release of insurance information and payment of medical/vision benefits if I choose to use an insurance plan for which the doctors are providers.

_____	_____	___/___/___
Patient Name (Printed)	Patient Signature	Date
_____	_____	___/___/___
Parent/Guardian Name (Printed)	Parent/Guardian Signature	Date