

Patient Name: \_\_\_\_\_ Male/Female (CIRCLE) DOB: \_\_\_\_\_

Email: \_\_\_\_\_ Do you want a reminder for next year's exam: Y/ N (CIRCLE)

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_\_ Last Eye Dr.: \_\_\_\_\_ Primary Care Dr.: \_\_\_\_\_

<u>List any medications you are currently taking</u> <i>(Include prescription and over the counter meds)</i>	<u>Dose</u>	<u>How often?</u>	<u>How do you take?</u> <i>(pill, syrup, injection, etc.)</i>
<u>List any allergies to medication:</u>			

<u>Patient's Health History (circle)</u>	<u>Describe/Other</u>	<u>Patient History (continued)</u>	<u>Describe/Other</u>
<b>Are you pregnant or nursing?</b>		<b>Ears, Nose, Throat</b> (sinus, hearing loss)	
<b>Any surgeries in the past?</b>		<b>Lymph/Blood</b> (cholesterol, anemia, AIDS)	
<b>Eyes (blur, pain, discharge)</b>		<b>Integumentary/Skin</b> (herpes, acne, skin cancer)	
<b>Allergic/Immunologic</b> (hay fever, rheumatoid)		<b>Muscles, Bones, Joints</b> (arthritis, osteoporosis)	
<b>Cardiovascular</b> (high blood pressure, stroke)		<b>Neurological</b> (MS, Parkinson's)	
<b>Constitutional</b> (fever, fatigue, weight loss/gain)		<b>Psychiatric</b> (depression, anxiety)	
<b>Endocrine</b> (diabetes, pre-diabetes, thyroid, etc)		<b>Developmental/Behavioral</b> (autism, ADD)	
<b>Gastrointestinal (colitis, gastritis)</b>		<b>Respiratory</b> (asthma, emphysema)	
<b>Kidney, Bladder, Genital</b>			

<b>Do you smoke?</b>	<b>Y N</b>	<b>If yes, how much?</b>	<b>Do you drink alcohol?</b>	<b>Y N</b>	<b>If yes, how much?</b>
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<u>Family History (circle)</u>	<u>Describe/Relationship</u>	<u>Family History (continued)</u>	<u>Describe/Relationship</u>
<b>Eye Disease</b> (glaucoma, macular degeneration,)		<b>Cancer</b>	
<b>Diabetes</b>		<b>Stroke</b>	
<b>Heart Disease, High Blood Pressure</b>		<b>Other</b>	

**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

I authorize Traci L. Schmalle, OD, LLC to release the following information to a spouse, parent, or other family members:

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Phone \_\_\_\_\_

**Check appropriate:** Entire medical records \_\_\_ Financial information \_\_\_ Prescriptions \_\_\_ Other \_\_\_\_\_

**If you decline to release any information, please initial:** \_\_\_\_\_

**MEDICAL HISTORY ACCURACY AND OFFICE POLICIES**

My signature below attests that the above medical information is accurate and true to the best of my knowledge and that I accept the Office Policies of Traci L. Schmalle, OD, LLC as listed on the separate sheet.

\_\_\_\_\_  
**Signature (Patient, Parent or Legal Guardian if patient is under 18)**      **Print Name & Relationship to Patient**      **Date**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*(You have been provided with a copy of our Notice of Privacy Practices Effective September 23, 2013 ("Notice"). Please review the Notice carefully. The Notice is also displayed in our office.)*

By signing below, I acknowledge that I have reviewed Traci L. Schmalle, OD, LLC's Notice of Privacy Practices Effective September 23, 2013.

\_\_\_\_\_  
**Signature (Patient, Parent or Legal Guardian if patient is under 18)**      **Print Name & Relationship to Patient**      **Date**