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.**:_____

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

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

Family History (circle)	**Describe/Relationship**		**Family History (continued)**	**Describe/Relationship**
Eye Disease (glaucoma, macular degeneration)			**Cancer**	
Diabetes			**Stroke**	
Heart Disease, High Blood Pressure			**Other**	

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: _____

Would you like to have a Contact lens Evaluation done today? ____**Y** _____**N** (If no, you have only 6 months from today to come back for a contact lens evaluation ONLY. Otherwise, you would need to pay out of pocket for a whole new exam plus the evaluation fee for contact lens.)

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 (Of p*atient, 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**

Updated 05/05/17