



# SNODGRASS FAMILY EYECARE

Date: \_\_\_\_\_

Name (legal): \_\_\_\_\_ DOB: \_\_\_\_\_

Sex: F \_\_\_ M \_\_\_ Marital status: \_\_\_\_\_ Email \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

**Preferred Language:** English Other \_\_\_\_\_ Decline

**Race:** Asian American Indian or Alaska Native **Ethnicity:** Hispanic/Latino  
 Other race Black or African American Not Hispanic/Latino  
 White Unknown Decline

**Tobacco Use:** Current Former Never

**Please list any medications you are taking, including prescription medicines, over the counter eye drops, vitamins, or supplements:** None or \_\_\_\_\_

**Please list any allergies to medications:** None or \_\_\_\_\_

For office use only	
<input type="checkbox"/> file medical	<input type="checkbox"/> sched. follow-up
<input type="checkbox"/> file vision	<input type="checkbox"/> Dr's change
<input type="checkbox"/> screen photos	<input type="checkbox"/> lens warranty
<input type="checkbox"/> order trials	<input type="checkbox"/> frame warranty

**Family History** have your parents, siblings, or children been diagnosed with any of the following: **NO to all**

Cataracts \_\_\_\_\_ Macular Degeneration \_\_\_\_\_ Glaucoma \_\_\_\_\_

High blood pressure \_\_\_\_\_ Diabetes \_\_\_\_\_

**Review of systems:** Do you currently have any of the following?

**Constitution:**

\_\_\_ None  
\_\_\_ Cancer  
\_\_\_ Fatigue  
\_\_\_ Other \_\_\_\_\_

**ENT:**

\_\_\_ None  
\_\_\_ Sinusitis  
\_\_\_ Laryngitis  
\_\_\_ Hearing loss  
\_\_\_ Dry Mouth  
\_\_\_ Other \_\_\_\_\_

**Neurological:**

\_\_\_ None  
\_\_\_ Cerebral Palsy  
\_\_\_ Stroke/CVA  
\_\_\_ Multiple Sclerosis  
\_\_\_ Tumor  
\_\_\_ Other \_\_\_\_\_

**Psychology:**

\_\_\_ None  
\_\_\_ Anxiety Disorder  
\_\_\_ Other \_\_\_\_\_  
\_\_\_ Depression  
\_\_\_ Bipolar Disorder

**Cardiovascular:**

\_\_\_ None  
\_\_\_ Heart Disease  
\_\_\_ Congestive Heart Disease  
\_\_\_ Hypertension  
\_\_\_ Vascular Disease  
\_\_\_ Other \_\_\_\_\_

**Respiratory:**

\_\_\_ None  
\_\_\_ Asthma  
\_\_\_ Emphysema  
\_\_\_ Cigarette smoker  
\_\_\_ Bronchitis  
\_\_\_ Other \_\_\_\_\_

**Gastrointestinal:**

\_\_\_ None  
\_\_\_ Colitis  
\_\_\_ Acid Reflux  
\_\_\_ Crohn's Disease  
\_\_\_ Ulcer  
\_\_\_ Celiac Disease

**Genitourinary:**

\_\_\_ None  
\_\_\_ STD (herpetic/Chlamydia)  
\_\_\_ Prostate disease/Cancer  
\_\_\_ Other \_\_\_\_\_  
\_\_\_ Kidney Disease

**Musculoskeletal:**

\_\_\_ None  
\_\_\_ Osteoarthritis  
\_\_\_ Other \_\_\_\_\_  
\_\_\_ Arthritis  
\_\_\_ Osteoporosis

**Integumentary:**

\_\_\_ None  
\_\_\_ Psoriasis  
\_\_\_ Shingles  
\_\_\_ Eczema  
\_\_\_ Cold Sores  
\_\_\_ Other \_\_\_\_\_

**Endocrine:**

\_\_\_ None  
\_\_\_ Thyroid Dysfunction  
\_\_\_ Hormonal Dysfunction  
\_\_\_ Type 1 Diabetes  
\_\_\_ Type 2 Diabetes  
\_\_\_ Other \_\_\_\_\_

**Hematologic/Lymphatic:**

\_\_\_ None  
\_\_\_ Large volume blood loss  
\_\_\_ Gout  
\_\_\_ Anemia  
\_\_\_ High Cholesterol  
\_\_\_ Other \_\_\_\_\_

**Allergies/Immune:**

\_\_\_ None  
\_\_\_ Medications  
\_\_\_ Rheumatoid Arthritis  
\_\_\_ Other \_\_\_\_\_  
\_\_\_ Environmental  
\_\_\_ Lupus

Are you experiencing or have you been diagnosed with any of the following: or **NO to all**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Cataract       | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Diabetic Retinopathy   | <input type="checkbox"/> Macular Degeneration        |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Iritis/Uveitis       | <input type="checkbox"/> Floaters/light flashes | <input type="checkbox"/> Retina defects/degeneration |
| <input type="checkbox"/> Headache       | <input type="checkbox"/> Total loss of vision | <input type="checkbox"/> Dry eye                | <input type="checkbox"/> Redness                     |
| <input type="checkbox"/> Burning        | <input type="checkbox"/> Itching              | <input type="checkbox"/> Discharge              | <input type="checkbox"/> Sensitivity to light        |
| <input type="checkbox"/> Eye pain       | <input type="checkbox"/> Tearing              | <input type="checkbox"/> Eyestrain              | <input type="checkbox"/> Double vision               |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Poor night vision    | <input type="checkbox"/> Bothersome night glare |  |

Please list any vision or eye concerns: **None** or \_\_\_\_\_

Please list any eye surgeries or injuries : **None** or \_\_\_\_\_

### Screening Retinal Photography

Retinal photography is recommended at your first exam with us as a baseline. Dr. Snodgrass will review your photos with you during your exam and explain what he/she is observing. The retina is the nerve layer that lines the back of the eye, and photos will allow us to monitor for changes over time.

The fee for screening retinal photos is \$20.00 and is not covered by insurance.

I have read the above information about retinal photography.

\_\_\_\_\_ (initial) YES, I choose to have retinal photos.

\_\_\_\_\_ (initial) NO, I choose to decline retinal photos.

#### **Contact lens wearers :**

**\*\*** \_\_\_\_\_ (initial) **Please note that contact lens management fees are not usually covered by vision or medical insurance plans. Payment is expected on the day of service.\*\***

**Insurance Authorization (please sign below):** I authorize the release of information necessary to process my claims and the payment of benefits to Snodgrass Family Eyecare.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### **HIPPA Privacy Practice — Please sign and date. I was offered a copy of SFE's Privacy Practices**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Relationship if patient not signing:** \_\_\_\_\_

**Additional authorization:** We will only share your information as outlined in our privacy policy. You can choose to allow to share information with family or friends. I give permission for SFE to release information to:

\_\_\_\_\_