HAMBURG VISION CENTER

KAREN SANTOS, OD

Name:_____ Today's Date:____/____/_____

Address:_____ Home Phone:_____

City:_____State:_____Zip:_____ Cell Phone:_____

Birth Date:____/____/_____Social Sec.#_____/____/_____ Work Phone:_____

Email:_____ Employer:_____

Guardian (IF APPLICABLE):_____ Last Eye Exam:_____/_____/_____

Name of Medical Doctor:_____ Last Medical Exam:___/___/_____

Name of Emergency Contact:_____ Sex: M F

Emergency Contact Phone Number:_____ Marital Status:_____

If you were referred to us, who may we thank?_____

Do you have vision insurance? YES NO

Name of insurance company_____Policy Holder_____

Relationship to Policy Holder_____Policy Holder's SSN_____/_____/_____

Policy Holder's Birth Date_____/_____/_____

Do you have health insurance? YES NO

Name of insurance company_____Policy Holder_____

Relationship to Policy Holder_____Policy Holder's SSN_____/_____/_____

Policy Holder's Birth Date_____/_____/_____

Please bring all current insurance cards to your appointment along with photo ID.

Co-pays & deductibles are required on date of service. We will bill your insurance but cannot assure payment. You are fully responsible for payment.

Please give your insurance information to the receptionist on the date of service.

REVIEW OF SYSTEMS *Do you currently, or have you ever had any problems in the following areas:*

SYSTEM	NO	YES	SYSTEM	NO	YES
CONSTITUTIONAL			RESPIRATORY	☐	☐
Fever, Weight Loss / Gain	☐	☐	If yes, specify:_____		
EARS, NOSE, MOUTH, THROAT			GASTROINTESTINAL	☐	☐
Allergies / Hay Fever	☐	☐	If yes, specify: _____		
Sinus Congestion	☐	☐			
Runny Nose	☐	☐	GENITOURINARY		
Chronic Cough	☐	☐	Genitals / Kidney / Bladder	☐	☐
Dry Throat / Mouth	☐	☐	Currently Pregnant / Nursing	☐	
NEUROLOGICAL			BONES / JOINTS/ MUSCLES		
Headaches	☐	☐	Rheumatoid Arthritis	☐	☐
Migraines	☐	☐	Muscle Pain/Joint Pain	☐	☐
Seizures	☐	☐	Other	☐	
PSYCHIATRIC	☐	☐	ENDOCRINE		
(anxiety, depression, ADHD)			Thyroid / Other Glands	☐	☐
			Diabetes	☐	☐
VASCULAR / CARDIOVASULAR					
Heart Disease	☐	☐	IMMUNOLOGICAL	☐	☐
High Blood Pressure	☐	☐	(lupus, HIV, sjogrens)		
Vascular Disease	☐	☐	If yes, specify:_____		

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SYSTEM	NO	YES
LYMPHATIC / HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐

HEIGHT_____

WEIGHT_____

SOCIAL HISTORY

Do you use tobacco products? ☐ NO ☐ YES If yes, type / amount / how long:_____

Do you drink alcohol? ☐ NO ☐ YES If yes, type / amount / how long:_____

CURRENT MEDICATIONS

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies. (*If you have a written list of medications, the receptionist will make a copy.*)

_____

_____

_____

Do you have any allergies to medications? ☐ YES ☐ NO

If yes, explain:_____

PAST OCULAR HISTORY

Do you currently, or have you ever had any problems in the following areas:

	NO	YES		NO	YES
Loss of Vision	☐	☐	Blurred Vision	☐	☐
Distorted Vision / Halos	☐	☐	Loss of Side Vision	☐	☐
Double Vision	☐	☐	Redness	☐	☐
Discharge	☐	☐	Itching	☐	☐
Sandy or Gritty Feeling/Dryness	☐	☐	Excess Tearing / Watering	☐	☐
Burning	☐	☐	Eye Pain or Soreness	☐	☐
Glare / Light Sensitivity	☐	☐	Sties or Chalazion	☐	☐
Chronic Infection of Eye / Lid	☐	☐	Tired Eyes	☐	☐
Flashes / Floaters in Vision	☐	☐			

Other:_____

FAMILY HISTORY

DISEASE / CONDITION	NO	YES	DISEASE / CONDITION	NO	YES
Blindness	☐	☐	Cataract	☐	☐
Crossed Eyes/Strabismus/Amblyopia	☐	☐	Glaucoma	☐	☐
Macular Degeneration	☐	☐	Retinal Detachment / Disease	☐	☐
Cancer	☐	☐	Heart Disease	☐	☐
Diabetes	☐	☐	Kidney Disease	☐	☐
High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Lupus/Rheumatoid Arthritis	☐	☐			

HOBBIES / ACTIVITIES	NO	YES	HOBBIES / ACTIVITES	NO	YES
Computer	☐	☐	Sewing	☐	☐
Fishing / Boating / Water Sports	☐	☐	Contact Sports	☐	☐
Golf	☐	☐	Tennis	☐	☐
Gardening	☐	☐	Hunting	☐	☐
Scrap booking	☐	☐	Other:_____		

PATIENT SIGNATURE (GUARDIAN SIGNATURE IF MINOR):_____**DATE:**____/____/_____