Welcome to Desert Oasis Eye Care
Patient History Form

Last name_____ First_____ MI_____
Birthdate_____

Parent/Guardian (if patient is a minor)_____ Email Address_____

Address_____ City_____State_____ Zip _____

Phone – Home_____ Office_____
Cell_____

How do you prefer to be contacted? EMAIL PHONE MAIL TEXT Marital Status: S M W Sex: Male Female

Occupation_____ Employer or School (if patient is a student) _____

Emergency contact_____Phone_____

Primary Care Physician _____Email_____

Address_____
Phone_____

Whom may we thank for referring you?
_____

Insurance:

Responsible party_____ DOB_____ Relationship to you_____

Vision Insurance Carrier_____ Member ID #_____

Primary Medical Insurance_____ Member ID #_____

Personal History:

Date of last eye exam_____ Doctor Name_____

Do you currently wear contact lenses? Yes No If yes, which brand and solution_____

Have you ever worn contact lenses? Yes No If no, are you interested in trying? Yes No

Any Ocular injuries or eye surgeries?
_____

Any eye treatments?

_____

Cataracts/Glaucoma/Macular Degeneration/Eye Muscle/Lasik/RK/Other

Medications (including vitamins/supplements/over the counter)

_____

_____

_____

Medication Allergies or Reactions

_____

Family History: Cancer/Diabetes/Heart/ Hypertension/Lung/ Macular Degeneration/ Glaucoma/Other_____

National Healthcare Mandates – Please provide the following information:

Ethnicity: African American Asian Caucasian Hispanic/Latino Native American Other_____

Preferred language_____

Personal Medical History: Please circle all that apply

Cardiovascular
Aneurysm
Arrhythmia
Cholesterol
CHF
CAD
Heart Attack
Hypertension
Pacemaker

Ears Nose Throat
Allergies
Ear Infection
Sinusitis

Endocrine
Crohn's Disease
Diabetes
Gout
Pituitary
Thyroid

Gastrointestinal
Gastrointestinal Disorder
Cancer
Diverticulitis
Hepatitis
Reflux Disease

Genitourinary
Nephritis
Ovarian Cancer
Prostate Cancer
Renal Failure
UTI

Immunology
AIDS
Herpes Zoster
HIV
Lyme Disease
Tuberculosis

Skin (integumentary)
Lupus
Psoriasis
Rosacea
Skin Cancer

Social History: Smoke or use tobacco product Yes No

Consume alcohol Yes No

Lymphatic/Blood
Anemia
Leukemia
Lymphoma
Temporal Arteritis

Musculoskeletal
Arthritis
Fibromyalgia
Myasthenia Gravis
Osteoporosis
TMJ

Neurological
Alzheimer's
Headache
Muscular Dystrophy
Multiple Sclerosis
Parkinson's
Stroke/CVA
Seizures

Psychiatric
ADD/ADHD
Alcoholism
Anxiety Disorders
Depression
Drug Dependence
Panic Disorders
Other_____

Respiratory

Asthma
Bronchitis
COPD
Emphysema
Lung Cancer
Pneumonia
Women
Breast Cancer
Pregnant yes or no

If yes, how far along_____
Other
_____

If yes, how much/often? _____
If yes, how much/often? _____

I authorize and request that payments made under my insurance program(s) be made directly to Desert Oasis Eye Care and Optical for services furnished to me. I also authorize Desert Oasis Eye Care and Optical to release information needed in my treatment, payment of claims and healthcare operations. I further permit copies of this authorization to be used in place of the original. I realize that there might be a portion of my bill that will be my responsibility and do agree to pay this portion.

Signature_____Date_____
_____

I acknowledge that I have read and understand the Notice of Privacy Practices. A copy has been made available to me.

Signature_____Date_____
_____

Please list any other person(s) you wish to have access to your information_____