ASHWORTH VISION CLINIC
Dr. Barbara A. Scheetz
Dr. Todd R. Pietig
Doctors of Optometry

MEDICAL HISTORY

Today's Date___/___/____

Patient's Name (please print) _____Birth Date _____
Street Address_____ City_____ State_____ Zip Code_____
Home/Cell Phone_____ _____Work Phone _____ Last Four of SS#_____

FAMILY MEDICAL HISTORY

	YES	NO	NOT SURE	RELATIONSHIP TO PATIENT
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed eyes	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular degeneration	☐	☐	☐	_____

YOUR OCULAR HISTORY- EYE AND VISION

	YES	NO	NOT SURE		YES	NO	NOT SURE
Itchy eyes	☐	☐	☐	Macular Degeneration	☐	☐	☐
Blurriness	☐	☐	☐	Excess tearing/watering	☐	☐	☐
Cataract	☐	☐	☐	Floaters	☐	☐	☐
Redness	☐	☐	☐	Foreign body sensation	☐	☐	☐
Tired eyes	☐	☐	☐	Light sensitivity	☐	☐	☐
Double vision	☐	☐	☐	Eye soreness	☐	☐	☐
Dryness	☐	☐	☐	Infections of eye/lid	☐	☐	☐
Loss of Vision	☐	☐	☐	Styes/chalazion	☐	☐	☐
Glaucoma	☐	☐	☐	Other_____			

Do you wear glasses ☐Y ☐N If yes, how old is your present pair of lenses? _____
Do you wear contacts ☐Y ☐N If yes, how old is your present pair of lenses? _____

List any eyes diseases, injuries, or surgeries

_____
_____

CURRENTLY TAKING ANY MEDICATIONS? _____

PLEASE LIST ANY ALLERGIES YOU MAY HAVE:

_____
_____

Social History

ARE YOU PREGNANT OR NURSING ☐Yes ☐ No
Do you drive? ☐Yes ☐No If yes, do you have visual difficulty when driving? ☐Yes ☐No
Do you tobacco products ☐ yes ☐ No Do you drink alcohol? ☐yes ☐No
Do you use illegal drugs? ☐Yes ☐No If yes, type/amount/how long_____
Have you ever been exposed/infected with: ☐Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Please turn this form over and complete side two

Medical History

	YES	NO	NOT SURE	If yes, please explain
Endocrine	☐	☐	☐	_____
Ear/Nose/Throat	☐	☐	☐	_____
Respiratory	☐	☐	☐	_____
Vascular/ Cardiovascular	☐	☐	☐	_____
Gastrointestinal	☐	☐	☐	_____
Musculosketal Problems	☐	☐	☐	_____
Lymphatic/ Hematologic	☐	☐	☐	_____
Allergic/ Immunologic	☐	☐	☐	_____
Psychiatric	☐	☐	☐	_____
Neurological	☐	☐	☐	_____
Integumentary	☐	☐	☐	_____
Genitourinary (G.U)	☐	☐	☐	_____
Constitutional/ Symptom	☐	☐	☐	_____

Have you had any surgeries? _____

If you answered YES to any of the above or have a condition that is not listed, please explain:

_____

_____

_____

_____

HIPAA COMPLIANCE ACKNOWLEDGEMENT

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations you may complain to us using the contact information listed at the end of this notice. You may also submit a written compliant to the US Department of Health and Human Services. We will provide you with the address to file your compliant with US Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

If you want more information about our privacy practices or have questions or concerns, please contact us.
Contact person: **Elisha Clark** Telephone: **(515) 440-4610** Fax: **(515) 440-4611**
Email: **Ashworthvision@msn.com** Address: **5970 Ashworth Rd West Des Moines, IA 50266**

I acknowledge that I have read the Notice of Privacy Practices_____ _____
Patient Name Date

Signature_____
Patient or Person Authorized to Consent to Patient