ASHWORTH VISION CLINIC

Today's Date:____/____/____

# MEDICAL HISTORY

Patient Name_____ Date of Birth ____/____/____

**YOUR FAMILY HISTORY**

| | YES | NO | RELATIONSHIP TO PATIENT |
|---|---|---|---|
| Blindness | ☐ | ☐ | _____ |
| Cataract | ☐ | ☐ | _____ |
| Crossed eyes | ☐ | ☐ | _____ |
| Arthritis | ☐ | ☐ | _____ |
| Cancer | ☐ | ☐ | _____ |
| Diabetes | ☐ | ☐ | _____ |
| Heart Disease | ☐ | ☐ | _____ |
| High Blood pressure | ☐ | ☐ | _____ |
| Glaucoma | ☐ | ☐ | _____ |
| Macular degeneration | ☐ | ☐ | _____ |

## Social History

**ARE YOU PREGNANT OR NURSING?** ☐Yes ☐ No

**DO YOU USE TOBACCO PRODUCTS?** ☐Yes ☐ No

**DO YOU DRINK ALCOHOL?** ☐Yes ☐ No

**DO YOU USE RECREATIONAL DRUGS?** ☐Yes ☐ No

**If yes, type/amount/how long?**

_____

## Your Medical History

| | YES | NO | | YES | NO | PLEASE EXPLAIN IF YOU ANSWERED 'YES' TO ANY OF THESE: |
|---|---|---|---|---|---|---|
| Endocrine (Diabetes) | ☐ | ☐ | Musculosketal Problems | ☐ | ☐ | |
| Ear/Nose/Throat | ☐ | ☐ | Lymphatic / Blood | ☐ | ☐ | _____ |
| Respiratory | ☐ | ☐ | Allergic / Immunologic | ☐ | ☐ | |
| Vascular / Cardiovascular | ☐ | ☐ | Psychiatric | ☐ | ☐ | _____ |
| Gastrointestinal | ☐ | ☐ | Neurological | ☐ | ☐ | |
| Genitourinary (GU) | ☐ | ☐ | Integumentary | ☐ | ☐ | _____ |

**YOUR OCULAR HISTORY- EYE AND VISION**

| | YES | NO | | YES | NO | | YES | NO | List any eyes diseases, injuries or surgeries: |
|---|---|---|---|---|---|---|---|---|---|
| Itchy eyes | ☐ | ☐ | Macular Degeneration | ☐ | ☐ | Double vision | ☐ | ☐ | |
| Blurriness | ☐ | ☐ | Excess tearing/watering | ☐ | ☐ | Dryness | ☐ | ☐ | _____ |
| Cataract | ☐ | ☐ | Floaters | ☐ | ☐ | Glaucoma | ☐ | ☐ | |
| Redness | ☐ | ☐ | Light sensitivity | ☐ | ☐ | Eye soreness | ☐ | ☐ | _____ |
| | | | Tired eyes | ☐ | ☐ | Styes/chalazion | ☐ | ☐ | |
| | | | | | | | | | _____ |

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

**Do you wear contacts?** ☐Y ☐N If yes, brand/prescription: _____

**PLEASE LIST ANY ALLERGIES:**

_____

_____

_____

_____

**PLEASE LIST ANY MEDICATIONS: (including eye drops, birth control, and vitamins)**

_____ _____

_____ _____

_____ _____

_____ _____

**PLEASE LIST ANY SURGERIES YOU HAVE HAD:**

_____

_____

_____

_____

**HIPAA COMPLIANCE ACKNOWLEDGMENT**

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 to alternative locations you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint 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 practicies 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**

**Primary Care Provider that we may communicate with regarding your health information if necessary:**_____

I acknowledge that I have read the Notice of Privacy Practices_____ _____

Patient Name Date

Signature_____

Patient or Person Authorized to Consent to Patient