Welcome To Our Office

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Today's Date _____ Title: Mr. Mrs. Miss Ms. Other _____

Patient's Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell (_____) _____

If Married, Name of Spouse _____ If Child, Name of Parent (s) _____

How were you referred to our office? _____ Your Occupation _____

Does your work require special vision needs? _____ If so, please explain _____

Do you work at a computer or video display terminal Yes ___ No ___ E-Mail Address _____

Do you wear eyeglasses? Yes ___ No ___ If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? Yes ___ No ___ If no, are you interested in contact lenses? Yes ___ No ___ Tinted/colored? ___

If yes, how old is your present pair of lenses? _____ Type: Rigid ____ Soft ____ Extended wear ____ Other ____

Social Security # _____ Driver's License # _____ State _____ Vision Plan _____

Medicare # _____ Other Group Health Plan and/or Supplement Ins # _____

MEDICAL HISTORY

Date of Last Eye Exam _____

Medical Dr. _____ Telephone # _____ Last Medical Exam _____

Do you have any allergies to medications Yes ___ No ___ If yes, explain _____

List any/all medications you take (including oral contraceptives, aspirin, over the counter medications, vitamin supplements, and alternative remedies) _____

List all major injuries, surgeries and/or hospitalization you have had _____

Are you pregnant and/or nursing? Yes ___ No ___

In case of emergency, contact _____ phone # _____

PLEASE NOTE ANY **FAMILY** HISTORY (parents, siblings, children, living or deceased) for the following conditions:

DISEASE/CONDITION				RELATIONSHIP TO YOU
Heart Disease	❑ Yes	❑ No	❑ ?	_____
High Blood Pressure	❑ Yes	❑ No	❑ ?	_____
Kidney Disease	❑ Yes	❑ No	❑ ?	_____
Ulcers	❑ Yes	❑ No	❑ ?	_____
Thyroid Disease	❑ Yes	❑ No	❑ ?	_____
Diabetes	❑ Yes	❑ No	❑ ?	_____
Arthritis	❑ Yes	❑ No	❑ ?	_____
Lung Disease	❑ Yes	❑ No	❑ ?	_____
Cancer	❑ Yes	❑ No	❑ ?	_____
Lupus	❑ Yes	❑ No	❑ ?	_____
Retinal Detach/Disease	❑ Yes	❑ No	❑ ?	_____
Cataract	❑ Yes	❑ No	❑ ?	_____
Glaucoma	❑ Yes	❑ No	❑ ?	_____
Macular Degeneration	❑ Yes	❑ No	❑ ?	_____

**** PLEASE TURN THIS OVER TO COMPLETE YOUR HISTORY****

SOCIAL HISTORY *this information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Yes _____ I would prefer to discuss my social history information directly with my doctor. (Check space).

Do you drive? Yes ____ No ____ If yes, do you have visual difficulty when driving? Yes ____ No ____ If yes, please describe:

_____

Do you use tobacco products? Yes ____ No ____ If yes, the type/amount/how long? _____

Do you drink alcohol? Yes ____ No ____ If yes, type/amount/how long? _____

Have you ever been exposed to or infected with: _____ Gonorrhea ____ Hepatitis ____ HIV ____ Syphilis

REVIEW OF SYSTEMS

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

CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT				
Fever, Weight loss/gain	❑ Yes	❑ No	❑ ?	Allergies/Hay fever	❑ Yes	❑ No	❑ ?	
INTEGUMENTARY (skin)	❑ Yes	❑ No	❑ ?	Sinus congestion	❑ Yes	❑ No	❑ ?	
NEUROLOGICAL				Runny nose	❑ Yes	❑ No	❑ ?	
Headaches	❑ Yes	❑ No	❑ ?	Post-nasal drip	❑ Yes	❑ No	❑ ?	
Migraines	❑ Yes	❑ No	❑ ?	Chronic cough	❑ Yes	❑ No	❑ ?	
Seizures	❑ Yes	❑ No	❑ ?	Dry throat/Mouth	❑ Yes	❑ No	❑ ?	
EYES				RESPIRATORY				
Loss of vision	❑ Yes	❑ No	❑ ?	Asthma	❑ Yes	❑ No	❑ ?	
Blurred vision	❑ Yes	❑ No	❑ ?	Chronic bronchitis	❑ Yes	❑ No	❑ ?	
Distorted vision/halos	❑ Yes	❑ No	❑ ?	Emphysema	❑ Yes	❑ No	❑ ?	
Loss of side vision	❑ Yes	❑ No	❑ ?	VASCULAR / CARDIOVASCULAR				
Double vision	❑ Yes	❑ No	❑ ?	Diabetes	❑ Yes	❑ No	❑ ?	
Dryness	❑ Yes	❑ No	❑ ?	Heart pain	❑ Yes	❑ No	❑ ?	
Mucous discharge	❑ Yes	❑ No	❑ ?	High blood pressure	❑ Yes	❑ No	❑ ?	
Redness	❑ Yes	❑ No	❑ ?	Vascular disease	❑ Yes	❑ No	❑ ?	
Sandy or gritty feeling	❑ Yes	❑ No	❑ ?	GASTROINTESTINAL				
Itching	❑ Yes	❑ No	❑ ?	Diarrhea	❑ Yes	❑ No	❑ ?	
Burning	❑ Yes	❑ No	❑ ?	Constipation	❑ Yes	❑ No	❑ ?	
Foreign body sensation	❑ Yes	❑ No	❑ ?	GENITOURINARY				
Excess tearing/watering	❑ Yes	❑ No	❑ ?	Genitals/kidney/bladder	❑ Yes	❑ No	❑ ?	
Glare/light sensitivity	❑ Yes	❑ No	❑ ?	BONES / JOINTS / MUSCLES				
Eye pain or soreness	❑ Yes	❑ No	❑ ?	Rheumatoid Arthritis	❑ Yes	❑ No	❑ ?	
Chronic infection eye or lid	❑ Yes	❑ No	❑ ?	Muscle pain	❑ Yes	❑ No	❑ ?	
Sties or chalazion	❑ Yes	❑ No	❑ ?	Joint pain	❑ Yes	❑ No	❑ ?	
Flashes/floaters in vision	❑ Yes	❑ No	❑ ?	LYMPHATIC / HEMOTOLOGIC				
Tired eyes	❑ Yes	❑ No	❑ ?	Anemia	❑ Yes	❑ No	❑ ?	
ENDOCRINE				Bleeding problems	❑ Yes	❑ No	❑ ?	
Thyroid	❑ Yes	❑ No	❑ ?	ALLERGIC / IMMUNOLOGIC	❑ Yes	❑ No	❑ ?	
Other glands	❑ Yes	❑ No	❑ ?	PHYCHIATRIC	❑ Yes	❑ No	❑ ?	

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

_____

_____

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits. And I authorize payment of these benefits directly to TAD R. KOSANOVICH O.D., P.A. on my behalf for any services and materials furnished. I authorized any holder of Medical information about me to release to the health care financing administration and its agents any insurance coverage. My signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Patient Signature _____ Date _____