# H.M. Calvert M.D. & Associates

## WELCOME TO OUR OFFICE

(PLEASE PRINT)

Today's Date:_____

Name:_____ Age:_____Date of Birth:_____

Street:_____ Sex: M____ F____

City:_____State_____Zip_____ Vision Insurance:_____

Home Phone:_____Work Phone:_____ Medical Insurance:_____

Name of Medical Doctor:_____ Social Security #:_____

Location of Medical Doctor:_____ Date of Last Eye Exam:_____

Occupation (or Grade):_____ Date of Last Medical Exam:_____

Emergency Contact Name & Phone Number:_____

## Medical History

Do you have any allergies to medications?: _____

List any Medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

Please list any eye diseases, disorders, injuries, or issues:

_____

_____

Are you pregnant or nursing? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes

Do you currently wear contacts? ☐ No ☐ Yes

*If not, would you like to try contacts?* ☐ No ☐ Yes

**If currently wearing contacts**

Are they comfortable? ☐ No ☐ Yes

Do you sleep in your contacts? ☐ No ☐ Yes ☐ Occasionally

## Family History

**(Please Check all That Apply)**

| Disease / Condition | ☐ | RELATIONSHIP TO YOU (parents, grandparents, siblings, children, living or deceased) |
|---|---|---|
| Blindness | ☐ | |
| Cataract | ☐ | |
| Crossed Eyes | ☐ | |
| Glaucoma | ☐ | |
| Macular Degeneration | ☐ | |
| Retinal Detachment / Disease | ☐ | |
| Arthritis | ☐ | |
| Cancer | ☐ | |
| Diabetes | ☐ | |
| Heart Disease | ☐ | |
| High Blood Pressure | ☐ | |
| Kidney Disease | ☐ | |
| Lupus | ☐ | |
| Thyroid Disease | ☐ | |
| Other _____ | | |

**Please Complete Both Sides**

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

| | | | |
|---|---|---|---|
| Do you drive? | ☐ No ☐ Yes | If yes, do you have visual difficulty when driving? | ☐ No ☐ Yes |
| Do you use tobacco products? | ☐ No ☐ Yes | If yes, type / amount / how long: | _____ |
| Do you drink alcohol? | ☐ No ☐ Yes | Do you use illegal drugs? | ☐ No ☐ Yes |

# Personal Medical History (Please Check all That Apply)

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

| | | | | | |
|---|---|---|---|---|---|
| **Eyes** | | **Ears, Nose, Mouth, Throat** | | **Vascular / Cardiovascular** | |
| Loss of Vision | ☐ | Allergies / Hay Fever | ☐ | Diabetes | ☐ |
| Blurred Vision | ☐ | Sinus Congestion | ☐ | Heart Pain | ☐ |
| Distorted Vision / Halos | ☐ | Runny Nose | ☐ | High Blood Pressure | ☐ |
| Loss of Side Vision | ☐ | Post-Nasal Drip | ☐ | Vascular Disease | ☐ |
| Double Vision | ☐ | Chronic Cough | ☐ | **Gastrointestinal** | |
| Dryness | ☐ | Dry Throat/ Mouth | ☐ | Diarrhea | ☐ |
| Mucous Discharge | ☐ | **Respiratory** | | Constipation | ☐ |
| Redness | ☐ | Asthma | ☐ | **Genitourinary** | |
| Sandy or Gritty Feeling | ☐ | Chronic Bronchitis | ☐ | Genitals/ Kidney/ Bladder | ☐ |
| Itching | ☐ | Emphysema | ☐ | **Bones / Joints / Muscles** | |
| Burning | ☐ | **Constitutional** | | Rheumatoid Arthritis | ☐ |
| Foreign Body Sensation | ☐ | Fever, Weight Loss / Gain | ☐ | Muscle Pain | ☐ |
| Excess Tearing / Watering | ☐ | **Integumentary (skin)** | ☐ | Joint Pain | ☐ |
| Glare / Light Sensitivity | ☐ | **Neurological** | | **Lymphatic / Hematologic** | |
| Eye Pain or Soreness | ☐ | Headaches | ☐ | Anemia | ☐ |
| Chronic Infection of Eye or Lid | ☐ | Migraines | ☐ | Bleeding Problems | ☐ |
| Stye or Chalazion | ☐ | Seizures | ☐ | **Allergic / Immunologic** | ☐ |
| Flashes / Floaters in Vision | ☐ | **Endocrine** | | **Psychiatric** | ☐ |
| Tired Eyes | ☐ | Thyroid / Other Glands | ☐ | | |

**If you checked any of the above or have a condition or illness not listed, please explain & list all major injuries, surgeri and / or hospitalizations you have had:**

## Please Read Carefully:

Your eye exam includes much more than just checking your vision, it is of the utmost importance to assure that your eyes are healthy and disease free. In order for your Doctor to examine your eyes adequately it may be necessary to to have additional testing done during the exam. These procedures may incur a small additional fee. We only perform tests that the Doctor feels necessary in order to identify and treat possible ocular conditions. If you have any questions about these fees or tests please let a member of our staff know and they will be happy to answer any questions for you.

**By Signing below:**

1) Acknowledgement is given of receipt of H.M. Calvert MD & Associates Notice of Privacy Practices in compliance with H.I.P.A

2) You are authorizing H.M. Calvert MD & Associates and LensCrafters to disclose your individual health information (i.e. name, address, telephone #, appointment dates and time) for the purpose of recalling lists to remind you of your next appointment time and to provide you with coupons and service and product information either from this office or directly from LensCrafters.

3) You are agreeing that if your payment for services and/or materials rendered is ever uncollectable (i.e returned check or lapse insurance coverage) that you will be responsible for payment of any and all collection costs if necessary. You hereby agree to assume the responsibility of any copayment and balances remaining after payment is made that are not covered by your insurar You hereby authorize release of any information with respect to your claim and certify that the information furnished in support o the claim is true and correct.

**Patient's Signature:** **Doctor's Signature:** **Date:**