dr. mike m. sandy

Name: _____ Age: _____ Today's Date: _____ / _____ / _____

Address: _____ Phone: _____

City, State: _____ Zip: _____ Work: _____

Birth Date: _____ / _____ / _____ Last Eye Exam: _____ / _____ / _____ Occupation: _____

Employer: _____

Name of Vision Benefit Plan: _____ Name of Policy Holder: _____

Name of Medical Insurance: _____ Name of Policy Holder: _____

Employer of Policy Holder: _____ Birth Date of Policy Holder: _____ / _____ / _____

Do you have any allergies? ❒ yes ❒ no If yes, explain: _____

_____

List any medications, prescribed or over the counter, that you take: (If you have a list of your medications, we can scan it into your chart)

_____

_____

_____

_____

LIST ANY OF THE FOLLOWING THAT YOU HAVE HAD: eye surgery, cataracts, glaucoma, retinal disease, eye injury:

_____

Are you pregnant and/or nursing? ❒ yes ❒ no

Do you wear glasses? ❒ yes ❒ no If yes, how old is your present pair of glasses? _____

Do you wear contact lenses? ❒ yes ❒ no If yes, what brand do you wear? _____

What power contacts do you wear? _____

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	YES	NO	?	SELF OR RELATIONSHIP TO YOU
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 continue to next page

Do you have visual difficulty when driving? ❒ yes ❒ no If yes, please describe:

_____

How often do you experience headaches? ❒ Daily ❒ Weekly ❒ Intermittently ❒ Rarely ❒ Never

What do you feel is the cause(s) of these headaches? ❒ Sinus/Allergies ❒ Stress ❒ Diet/Caffeine ❒ Sleep ❒ Vision

Other? Please describe: _____

Review of Systems

Do you have any PROBLEMS in the following areas:

	YES	NO	?
GENERAL HEALTH			
Acute Fever, Weight Loss/Gain	❒	❒	❒
SKIN PROBLEMS	❒	❒	❒
NEUROLOGICAL			
Dizziness	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
EYES			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection of Eye or Lid	❒	❒	❒
Styes	❒	❒	❒
Flashes/Floaters in Vision	❒	❒	❒
Tired Eyes	❒	❒	❒
ENDOCRINE			
Thyroid/Other Glands	❒	❒	❒
LYMPHATIC / HEMATOLOGIC			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
SLEEP APNEA	❒	❒	❒
Do you use a CPAP?	❒	❒	❒

	YES	NO	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
RESPIRATORY			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
VASCULAR / CARDIOVASCULAR			
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
Heart Pain	❒	❒	❒
DIABETES (if yes, answer the following)	❒	❒	❒
When were you diagnosed? _____			
Most Recent HbA1c? _____			
Most Recent Blood Sugar? _____			
GASTROINTESTINAL			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
GENITOURINARY			
Genitals/Kidney/Bladder	❒	❒	❒
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
IMMUNE SYSTEM	❒	❒	❒
PSYCHIATRIC	❒	❒	❒
OTHER NOT LISTED _____			
DO YOU USE TOBACCO PRODUCTS?	❒	❒	

I certify that I have answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits for services rendered. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or those of my dependents. I understand that all fees are due at the time of service and are non-refundable. I have read and understand the HIPAA privacy policies for this office as posted.

X _____ _____

SIGNATURE OF PATIENT (or parent if patient is a minor) DATE