NEW PATIENT MEDICAL HISTORY

Name:_____ Birth Date_____ Age_____

Address_____ E-mail Address_____

City/State/Zip_____ Primary Care Physician_____

Phone: Home _____ Cell_____ Work _____
Preferred contacts for messages (mark all that apply): ❑Cell ❑Home ❑Work ❑E-mail ❑Text

Medications you are taking:❑none_____

_____

Allergies to medications: ❑none_____ _____
Major injuries, surgeries or hospitalizations:_____
For women, are you pregnant or nursing? ❑Yes ❑No

Do you or any of your family members have any of the following eye or medical problems?

	None	Self	Family		None	Self	Family
Cataracts	❑	❑	❑	Diabetes or Borderline Diabetes	❑	❑	❑
Glaucoma	❑	❑	❑	High Blood Pressure	❑	❑	❑
Macular Degeneration	❑	❑	❑	Cholesterol	❑	❑	❑
Stabismus or Crossed Eyes	❑	❑	❑	Heart Condition	❑	❑	❑
Ambloypia or lazy eye	❑	❑	❑	Stroke	❑	❑	❑
Other_____				Cancer	❑	❑	❑

Do you have any of the following eye conditions?

Dryness or Burning	❑	❑	Blurry Vision	❑	❑
Sandy or Gritty Feeling	❑	❑	Tired Eyes	❑	❑
Excess Tearing or Watering	❑	❑	Double Vision	❑	❑
Redness	❑	❑	Flashes or Floaters in vision	❑	❑
Itching	❑	❑	Glare or Light Sensitivity	❑	❑
Other_____			Previous Eye Surgery_____		

Do you have any of the following medical conditions?

Allergies/Hay Fever	❑	❑	Skin Conditions	❑	❑
Headaches	❑	❑	Thyroid condition	❑	❑
Seizures	❑	❑	Arthritis orJoints	❑	❑
Depression/Anxiety	❑	❑	Blood disorder or anemia	❑	❑
Attention Deficit	❑	❑	Asthma or Emphysema	❑	❑
HIV positive	❑	❑	Auto-Immune Condition	❑	❑
Other_____			Do you smoke?	❑	❑

INSURANCE SIGNATURE ON FILE
I authorize Sandra Davidson, OD, Inc, to help me obtain payment from my insurance and I request that payment of these benefits be made on my behalf to her for any services and materials furnished. I understand that I am responsible for all services and materials provided even if my insurance does not pay as expected.

Patient Signature_____ Date_____

RELEASE OF EXAMINATION FINDINGS
I authorize Drs. Davidson or Keltner to send a report of my examination to my physician, referring doctor or referring Health Professional. I also authorize Drs. Davidson or Keltner to discuss the results of my examination to the following individuals:

Name	Relationship
_____	_____
_____	_____
_____	_____

Patient Signature_____ Date_____

I have received Sandra Davidson, OD, Inc's Patient Confidentiality Policy

Patient Signature_____ Date_____