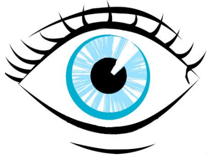

BRIGHTWOOD EYE CENTER
THE OFFICE OF DRS. FRANK AND JUDITH SPAETH

MEDICAL HISTORY

6611 BURLINGTON RD. WHITSETT, NC 27377 336-449-1333 WWW.BRIGHTWOODEYE.COM

PATIENT NAME____________________________

DO YOU WEAR GLASSES? YES NO

WHEN ? ________________________________

DO YOU WEAR CONTACT LENSES? YES NO

WHEN? _________________________________

HOURS PER DAY __________________________

BRAND OF CONTACTS ______________________

ANY PROBLEMS WITH YOUR CONTACTS?

____

____

PRIMARY CARE PHYSICIAN'S NAME:

____

NAME OF PRACTICE:

____

DATE OF LAST PHYSICAL EXAM ___________

NAME OF LAST EYE DOCTOR SEEN:

____

NAME OF PRACTICE:

____

DATE OF LAST EYE EXAM _______________

MEDICAL HISTORY

CHECK ANY OF THESE YOU OR A BLOOD RELATIVE HAS HAD:
YOU/ RELATIVE

___/___AIDS/HIV
___/___ARTHRITIS
___/___ARTIFICIAL JOINTS
___/___ASTHMA
___/___BLEEDING
___/___BLINDNESS
___/___CANCER
___/___DIABETES
___/___DRUG ABUSE
___/___DRUG SENSITIVE
___/___EMPHYSEMA
___/___EPILEPSY
___/___HAY FEVER
___/___HEART CONDITION
___/___HEPATITIS (TYPE___)
___/___HIGH BLOOD PRESS.
___/___KIDNEY DISEASE
___/___LAZY EYE
___/___LUPUS
___/___PACEMAKER
___/___RETINAL DISEASE
___/___RHEUMATIC FEVER
___/___SHINGLES
___/___SKIN CONDITIONS
___/___STROKE
___/___THYROID CONDITION
___/___TUBERCULOSIS
___/___TURNED EYE

OTHER MEDICAL ISSUES____________________________

____

ARE YOU PREGNANT? _____ NUMBER OF CHILDREN _____
DO YOU USE TOBACCO? ________ ALCOHOL? ___________

CHECK HERE IF NO KNOWN HEALTH ISSUES_______

MEDICATIONS YOU ARE CURRENTLY TAKING:

____
____
____
____

PHARMACY NAME ______________________

PHONE # (_____)_______________________

ALLERGIES: __________________________
____
____

EYE HEALTH HISTORY

PLACE A CHECK NEXT TO ANY OF THESE YOU HAVE HAD:

___ BLOODSHOT EYES
___ BLURRED VISION
___ BURNING EYES
___ CATARACTS
___ COLOR VISION, POOR
___ CROSSED EYES
___ DISCHARGE FROM EYES
___ DIZZY SPELLS
___ DOUBLE VISION
___ DRY EYES
___ EYE INFECTION
___ EYE INJURY
___ EYE STRAIN
___ EYE SURGERY
___ FAINTING, BLACKOUTS
___ FLOATERS OR SPOTS
___ GLAUCOMA
___ HEADACHES
___ ITCHING EYES
___ LIGHT SENSITIVE
___ LOSS OF VISION
___ MIGRAINES
___ NIGHT VISION, POOR
___ RED EYES
___ SEEING HALOS
___ SEEING FLASHES
___ TEMP. LOSS OF VISION
___ TWITCHING EYELID
___ VISION POOR
___ WATERING EYES

OTHER EYE HEALTH ISSUES__________________________

____

CHECK HERE IF NO KNOWN EYE HEALTH ISSUES ________

HIPPA ACKNOWLEDGEMENT AND DISCLOSURE

I _________________________________(FULL LEGAL NAME) HAVE BEEN PRESENTED WITH THE NOTICE OF PRIVACY POLICY OF BRIGHTWOOD EYE CENTER AND HAVE BEEN OFFERED A COPY OF SUCH POLICY TO KEEP FOR MY RECORDS. I UNDERSTAND THAT DISCLOSURES MAY BE MADE TO FAMILY AND FRIENDS RELATED TO MY HEALTH CARE SERVICES. I UNDERSTAND THAT ONLY INFORMATION RELEVANT TO CURRENT TREATMENT WILL BE DISCLOSED. I HAVE AGREED THAT HEALTH CARE INFORMATION MAY BE DISCLOSED TO THE FOLLOWING INDIVIDUALS:

FULL NAME	RELATIONSHIP
1. ______________________________	________________
2. ______________________________	________________
3. ______________________________	________________

SIGN ______________________________________

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR REPRESENTATIVE

DATE ______________________