Busby Eye Care
A MEMBER OF VISION SOURCE
Caring vision solutions that enhance your life

Patient History Form

Date _____

Name_____ Date of Birth_____

Address_____

Telephone (H)_____(C)_____SS#_____

Email_____ Text OK? Yes No Referred by_____

Spouse _____ List Family Members _____

Occupation _____ Employer _____Scheduled Appointment Date_____

Communication Preference (Circle one): Telephone Email Postal

Race (Circle One): American Indian or Alaskan Native Asian Black or African American

Hawaiian or Pacific Islander Hispanic White

Ethnicity (Circle One): Hispanic or Latino Native Hawaiian/Other Pacific Islander Not Hispanic or Latino

Preferred Language_____ Height_____ Weight_____ Tobacco use Y/ N

Date of Last Eye Exam _____

Medical Information

Do you have problems with any of these systems?

Eyes: Y/N	Gastrointestinal: Y/N	Nerves: Y/N	Ears/Nose/Throat: Y/N
Genitourinary: Y/N	Endocrine: Y/N	Cardiovascular: Y/N	Musculoskeletal: Y/N
Blood/Lymph: Y/N	Respiratory: Y/N	Psychiatric: Y/N	Allergy: Y/N
Constitutional: Y/N	Immunologic: Y/N	Integumentary (Skin): Y/N	

Please explain_____

Please answer all that apply

Diabetes: Y/N Type_____ Date of Diagnosis_____ Last HbA1C_____

Allergies: Y/N Allergic to what?_____

Medication Allergies: Y/N To what?

Do you currently experience: Headaches: Y/N Double Vision: Y/N New flashes or floaters: Y/N

Current Ocular Medications:_____

Current Systemic Medications:_____

Have you had any operations? Y/N Kind? _____ When?

Name of Family Doctor_____ Phone # _____

PERSONAL EYE INFORMATION

Have you had any eye surgeries? Y/N Type_____ Date_____

Have you had any eye injuries? Y/N Type_____ Date_____

Have you been diagnosed with: Glaucoma? Y/N Cataracts? Y/N Dry Eye? Y/N Blurred Vision Y/N

Other eye conditions: Y/N Explain_____ Date of last exam: _____

FAMILY MEDICAL HISTORY

High Blood Pressure: Y/N Relation_____ Diabetes: Y/N Relation_____

Other: Y/N Please explain_____ Relation_____

FAMILY EYE HISTORY

Macular Degeneration: Y/N Relation_____ Retinal Detachment: Y/N Relation_____

Glaucoma: Y/N Relation_____ Cataracts: Y/N Relation_____

Other Eye Conditions: Y/N What kind?_____ Relation_____

Insurance Information/Responsible Party

VISION INSURANCE

Insurance Company_____ Policy Holder's Employer_____

Name of insured_____ Relationship to patient_____

Birthdate _____ Social Security #_____

MEDICAL INSURANCE

Insurance Company_____ Policy Holder's Employer_____

Name of insured_____ Relationship to patient_____

Birthdate _____ Social Security #_____

_____ _____

Signature of patient (or parent if a minor) Date