MEDICAL INSURANCE: ***Please provide insurance card to the front desk at check-in.***

Name & date of birth of policyholder for insurance: _____

Insurance Provider: _____

Policy Number: _____

VISION PLAN: ***Please provide a card if available.***

Name & date of birth of policyholder for vision plan: _____

Plan Provider: _____

Policy Number: _____

MEDICAL HISTORY QUESTIONNAIRE: Yes = circle the condition, add or explain.

Eyes: Cataract, Glaucoma, Retinal issues, Macular Degeneration, eye surgery _____

Constitutional: chronic fever, fatigue, unexpected weight change _____

Cardiovascular: High BP, High Chol., chest pain, irregular heartbeat, pacemaker, shortness of breath _____

ENT: hearing loss, sore throat, sinus problems, vertigo _____

Respiratory: shortness of breath, asthma, bronchitis, sleep apnea, chronic lung conditions_____

Gastrointestinal: ulcer, heartburn, abdominal pain, IBS, diarrhea/constipation, vomiting, reflux _____

Genitourinary: issues with kidney, bladder, urinary, STDs, ovarian or prostrate issues/cancer _____

Musculoskeletal: arthritis, swollen joints, lupus, MS, fibromyalgia, gout, Sjogren's Syndrome _____

Integumentary: dermatitis, eczema, cellulitis, rash, melanoma, skin cancer _____

Neurological: seizures, paralysis, dementia, bell's palsy, Parkinson's disease, tremors, migraines _____

Psychiatric: depression, anxiety, confusion _____

Endocrine: Diabetes: Type 1 or 2, thyroid, Graves Disease, hormonal abnormality _____

Hematologic/Lymphatic: bleeding disorders, anemia, Leukemia, lymph node issues _____

Allergic/Immunologic: allergies to food or medicines, organ transplants, Lupus, HIV/AIDS _____

Other: _____

_____

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