Today's Date ________________

First Name MI	Last Name	Sex	Birthdate	Age

Home Address City State Zip	Daytime Phone	Cell Phone Text OK?
Occupation	Referred by	Preferred e-mail address

Name of your primary physician: ________________________________ Date of last medical exam: ____________________________

Please list any past eye / medical conditions or surgeries, with dates:

____

List any current significant illness or medical conditions, with dates:

____

List your current medications, with dates: ____

Do you have medication allergies? No known allergies Yes Please list: ____

List any family eye or medical conditions, and their relationship to you:

____

Year of last eye examination: ________________ Where seen: _______________________________ Last eye dilation: ______________

Contact lens wearers only. Please fill out the following information:

Which type of contact lenses do you wear? ________________________ Average number of days per week wearing contacts: _______

Average wearing time per day (in hours): __________________________ Contact lens solution brand: ___________________________

If disposable lenses, frequency of disposal: ________________________ Age of current pair of contact lenses: ___________________

How many years have you worn contact lenses? ____________________ Any current problems with lens wear ____________________

Do you currently experience any of the following symptoms or conditions:

	Yes	No	Office use only	
Migraines with aura			G43.109	V
Migraines without aura			G43.009	V
Floaters in vision			H43.393	EP
Flashes in vision			H53.8	V
Visual distortions			H53.19	EV
Blind spot area			H53.42*	V
Central blind spot			H53.41*	V

	Yes	No	Office use only	
Visual discomfort			H53.143	V
Eyestrain			H53.143	V
Light sensitivity			H53.143	V
Double vision			H53.2	V
Glare sensitivity			H53.71	V
Other visual disturbance			H53.8	V
Sudden visual loss			H53.13*	EV

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Christopher P. Young, OD Inc.

If signing as a personal representative, describe relationship to the patient and the source of authority to sign this form:

Signature: Date: