Hodges Woodall Optometry, PC

814 E Washington St • Greencastle, Indiana 46135

Patient Medical History Form

Today's Date: _____ /_____ /_____

☐ Ms. ☐ Mrs. ☐ Mr. ☐ Dr. Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed

Name: _____ Date of Birth: _____ /_____ /_____ Age:_____
(Last) (First) (Middle I.)

Address: _____ City: _____ State: _____ Zip: _____

Phone/Cell: _____ Email Address: _____

Vision Insurance:_____ Employer:_____ School/Grade: _____

Parent/Legal Guardian: _____ Date of Birth: ____ /____ /____
(If Applicable) (Last) (First) (Middle I.)

Date of Last Eye Exam Date: _____ Name/location of eye doctor: _____

Date of Last Medical Exam: _____ Name/location of medical doctor: _____

Medical History

List all current medications, including eye drops and non-prescription medications: _____

_____

_____

_____

List all allergies (medication, food, seasonal allergies, latex, etc…): _____

_____

_____

List all major surgeries, including eye surgeries: _____

_____

Are you pregnant or nursing? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No
Do you drink? ☐ Yes ☐ No

Ocular History

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your current pair? _____
Do you wear contacts? ☐ Yes ☐ No If no, are you interested in contacts today? ☐ Yes ☐ No
How many hours do you wear them each day? ☐ < 6 ☐ 6 - 12 ☐ 12 +
What type of contact lens solution do you use? ☐ BioTrue ☐ Opti-Free ☐ Renu ☐ ClearCare ☐ Generic ☐ ?

Check if you (the patient) or a family member (parent, grandparent, sibling, child) have had any of the following:

DISEASE	YOU	FAMILY	NO	DON'T KNOW	If family, what relationship to you?
Crossed or "lazy eye":	☐	☐	☐	☐	_____
Blindness:	☐	☐	☐	☐	_____
Cataract:	☐	☐	☐	☐	_____
Glaucoma:	☐	☐	☐	☐	_____
Macular degeneration:	☐	☐	☐	☐	_____
Retinal detachment:	☐	☐	☐	☐	_____
Arthritis:	☐	☐	☐	☐	_____
Cancer:	☐	☐	☐	☐	_____
Diabetes:	☐	☐	☐	☐	_____
Heart Disease:	☐	☐	☐	☐	_____
High blood pressure:	☐	☐	☐	☐	_____
Kidney Disease:	☐	☐	☐	☐	_____
Lupus:	☐	☐	☐	☐	_____
Thyroid Disease:	☐	☐	☐	☐	_____

Over

Record of Privacy Practice Notifications

I certify that I have been offered a copy of the office's Notice of Privacy Practices at my visit today:

Patient/ Legal Guardian Signature: ____

Date: ______________ **Only one signature per visit is required.**

I certify that I have been offered a copy of the office's Notice of Privacy Practices at my visit today:

Patient/ Legal Guardian Signature: ____

Date: ______________ **Only one signature per visit is required.**

I certify that I have been offered a copy of the office's Notice of Privacy Practices at my visit today:

Patient/ Legal Guardian Signature: ____

Date: ______________ **Only one signature per visit is required.**

I certify that I have been offered a copy of the office's Notice of Privacy Practices at my visit today:

Patient/ Legal Guardian Signature: ____

Date: ______________ **Only one signature per visit is required.**

I certify that I have been offered a copy of the office's Notice of Privacy Practices at my visit today:

Patient/ Legal Guardian Signature: ____

Date: ______________ **Only one signature per visit is required.**