MOSCOT
EYECARE

HEALTH HISTORY FORM

Last Name: ______________________________
First Name: ______________________________
Date of Birth: ______________________________
Address: ______________________________
Apt / Floor / Suite: ______________________________
City: ____________________ State: _____ ZIP: ________
Email: ______________________________
Home Phone: ______________________________
Cell Phone: ______________________________
Work Phone: ______________________________
Occupation: ______________________________
Employer: ______________________________
Reason for today's visit: ______________________________

INSURANCE INFORMATION

Using VSP today? ❑ Yes ❑ No
Primary Member's Name: ______________________________
Primary Member's SS#: ______________________________
Primary Member's DOB: ______________________________

MOSCOT POLICIES

If you need to cancel your appointment, kindly notify us *at least* 24-hours in advance. Failure to do so may result in a $40 cancellation fee.

❑ I understand to MOSCOT Eyecare's Policies.

I have read the HIPPA information and understand about my record security.

______________________________ ____________
Patient Signature Date

VSP members only: I authorize MOSCOT Eyecare to release any information to my insurance company for payment/reimbursement. I am personally responsible for payment of professional services rendered.

______________________________ ____________
Patient Signature Date

*Please be aware that our doctors routinely perform dilated eye exams to allow evaluation of your ocular health. This may cause blurred vision and light sensitivity for 2-3 hours afterward. If you have any questions, please discuss with doctor at time of exam. (Please choose below)

❑ Yes, dilate my eyes. ❑ No, I do NOT want my eyes dilated.

MEDICAL HISTORY

Date of last eye exam (approximate): ________________
Do you wear contact lenses? ❑ Yes ❑ No ❑ Interested
If yes, what kind? ______________________________
Solution(s) used: ______________________________
Hours per day working in a computer? ______________

Check the following you have experienced or have been treated for in the past:

❑ Blurred vision
❑ Eye infections
❑ Flashes of light
❑ Double vision
❑ Itchiness
❑ Cataracts
❑ Glaucoma
❑ Iritis / Uveitis
❑ Injury – if yes, specify____________
❑ Dry Eyes
❑ Floaters / Spots
❑ Lazy eye
❑ Watery eyes / tearing
❑ Eyestrain / tired eyes
❑ Headaches
❑ Macular Degeneration
❑ Retinal Detachment
❑ Eye Surgery – if yes, specify____________

Have you ever been diagnosed or treated for the following?

❑ Arthritis
❑ Diabetes
❑ Neurological
❑ Blood Disease
❑ Other: ____________
❑ Heart Disease
❑ High Cholesterol
❑ High Blood Pressure
❑ HIV / Hepatitis
❑ Autoimmune
❑ Thyroid Disease

Please list all medications you are taking (including eye drops and vitamins):

____
____
____

Are you allergic to any medications? ❑ Yes ❑ No
Do you have any other allergies? ❑ Yes ❑ No
If yes, please list:

____
____

Are you pregnant or nursing? ❑ Pregnant ❑ Nursing ❑ No
Do you smoke? ❑ Yes ❑ No

FAMILY HISTORY

	WHO
❑ Blindness	____________
❑ Cataracts	____________
❑ Glaucoma	____________
❑ Macular Degeneration	____________
❑ Retinal Detachment	____________
❑ Diabetes	____________
❑ High Blood Pressure	____________
❑ Heart Disease	____________
❑ High Cholesterol	____________
❑ Cancer	____________