Camille Silva, O.D
Behavioral Optometry and Vision Therapy
Adult History Form

I am pleased to welcome you to my practice. Please complete this questionnaire before your appointment.

Full Name _____Date of Birth_____

Home Address_____

Home telephone _____other telephone _____

Occupation _____Employer _____

D Single D Married D Widowed D Separated D Divorced

<u>Present Situation:</u> What has occurred that leads you to request a visual evaluation?

_____

Have you noticed any unusual signs or symptoms that concern you?

_____

Do you use a computer?_____ Number hours/day?_____

Date of last eye exam _____ Name of doctor_____

Do you wear glasses? D Yes D No D all the time □ reading D driving/TV

Do you wear contact lenses D Yes D No Any problems? _____

<u>Health History:</u> Check any conditions that apply to you or your family

Allergies ___self ___family
Diabetes ___self ___family
Heart Problem ___self ___family
Head trauma ___self ___family
Headaches ___self ___family
Migraines ___self ___family
Blindness ___self ___family
Thyroid ___self ___family
High Blood Pressure ___self ___family
Breathing Difficulty ___self ___family
AIDS/HIV+ ___self ___family
Artificial Heart Valve ___self ___family
Asthma ___self ___family
Hepatitis ___self ___family

Lazy Eye ___self ___family
Turned Eye ___self ___family
Light Sensitive___self ___family
Eyestrain ___self ___family
Dry Eyes ___self ___family
Floaters/spots ___self ___family
Flashing lights ___self ___family
Cataracts ___self ___family
Glaucoma ___self ___family
Eye surgery ___self ___family
Arthritis ___self ___family
Artificial joints ___self ___family
Cancer ___self ___family
Skin Problems ___self ___family

Name of Physician _____ Date of last physical

Name of medication taken

_____

Name of medicines that you are allergic to

_____

Other:

Recreational activities/sports _____

Number of hours/day watching television _____

Is there any other information about you that you think is important?

_____

_____

Insurance Information:

Subscriber name _____ Relationship to patient

Insurance Company _____ Group Number_

Birthdate_____ Policy Number _____

I, the undersigned acknowledge my financial responsibility. I understand that all fees are due at time of service unless otherwise arranged with Dr. Silva. Dr. Silva will provide necessary forms for insurance submittal. I am responsible for filing for insurance reimbursement.

_____ _____

signed **date**

Privacy Practice

By law, you are to be given notice of my privacy practices. This notice describes how I/we protect your health information and what rights you have regarding it. If you wish to review such notice, I will gladly supply you with a copy to either take with you or to review while you are here.

I have received the NOTICE OR PRIVACY PRACTICES and I have been provided an opportunity to review it.

_____ _____ _____

signed ***date of birth*** ***date***

Thank you very much for your time and effort in filling out this form.