Head to Toe Healthcare, PLC®
Advanced Eye and Foot Care
Optometrist & Podiatrist

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Name:____ **Guardian (If applicable):**______________________
Address:____ **Today's Date:**______/______/_______
City:_____________ **State:**_____________ **Zip:**___________ **Home Phone:** ________-________-__________
Birth Date:____/____/____ **Social Security (opt):**_______________ **Email:** ___________________________________
Occupation:________________ **Employer:**__________________ **Work Phone:** ________-________-__________
Primary Care Physician:_________________________________ **Cell Phone:** ________-________-__________
PCP Address:____ **Last Medical Exam:**__________________________
Previous Eye Physician:__________________________________ **Last Eye Exam:**_____________________________
How did you hear about us?____

☐ **Was the HIPAA – Notice of Privacy Practices form made available to you?** __________**(Please initial)**

1) EYE CHIEF COMPLAINT (TODAY)

Blurred Vision	**Yes** ☐ **No** ☐	**Foreign Body Sensation**	**Yes** ☐ **No** ☐
Burning	**Yes** ☐ **No** ☐	**Glare/ Light sensitivity**	**Yes** ☐ **No** ☐
Eye/ Lid Infection	**Yes** ☐ **No** ☐	**Itching**	**Yes** ☐ **No** ☐
Distorted Vision/ Halos	**Yes** ☐ **No** ☐	**Loss of Side Vision**	**Yes** ☐ **No** ☐
Double Vision	**Yes** ☐ **No** ☐	**Loss of Vision**	**Yes** ☐ **No** ☐
Dryness	**Yes** ☐ **No** ☐	**Mucous Discharge**	**Yes** ☐ **No** ☐
Excess Tearing/ Watering	**Yes** ☐ **No** ☐	**Redness**	**Yes** ☐ **No** ☐
Eye Pain/ Soreness	**Yes** ☐ **No** ☐	**Sandy/ Gritty Feeling**	**Yes** ☐ **No** ☐
Flashes/ Floaters in Vision	**Yes** ☐ **No** ☐	**Tired Eyes**	**Yes** ☐ **No** ☐

If you answered *Yes* to any of the above or have a condition not listed, please explain:______________________________
____

2) OCULAR CONDITIONS

Glaucoma	**Yes** ☐ **No** ☐	**Blindness**	**Yes** ☐ **No** ☐
Cataracts	**Yes** ☐ **No** ☐	**Crossed Eyes/Strabismus**	**Yes** ☐ **No** ☐
Macular Degeneration	**Yes** ☐ **No** ☐	**Lazy Eye/Amblyopia**	**Yes** ☐ **No** ☐
Eye Injury	**Yes** ☐ **No** ☐	**Diabetic Retinopathy**	**Yes** ☐ **No** ☐
Retinal Disease/Condition	**Yes** ☐ **No** ☐	**Dry Eyes**	**Yes** ☐ **No** ☐
Other Ocular Condition	**Yes** ☐ **No** ☐	**Refractive Surgery**	**Yes** ☐ **No** ☐

3) MEDICAL HISTORY

Do you have any allergies or allergies to medication?
____
List ANY medications you take prescription or over the counter:
____
List ALL current health conditions:
____
List ALL major injuries, surgeries and hospitalization:
____

Are you pregnant or nursing?	**Yes** ☐ **No** ☐		
Do you wear glasses?	**Yes** ☐ **No** ☐	**How old is your present pair?**_________________________	
Do you wear contact lenses?	**Yes** ☐ **No** ☐	**How old is your current pair?**_________________________	
What type of contact lenses?	**Hard** ☐ **Soft** ☐	**Do you sleep in them?**	**Yes** ☐ **No** ☐
Are they comfortable?	**Yes** ☐ **No** ☐	**How often do you change/dispose of your CL?** _____________	
Interested in refractive surgery?	**Yes** ☐ **No** ☐		

4) FAMILY HISTORY

Disease/ Condition:		**If yes, please indicate which relative; specify maternal or paternal if necessary**
Glaucoma	**Yes** ☐ **No** ☐	____
Cataracts	**Yes** ☐ **No** ☐	____
Macular Degeneration	**Yes** ☐ **No** ☐	____
Eye Injury	**Yes** ☐ **No** ☐	____

Retinal Detachment/Disease	**Yes ☐ No ☐**	______
Other Diseases	**Yes ☐ No ☐**	______
Blindness	**Yes ☐ No ☐**	______
Crossed Eye/Lazy Eye	**Yes ☐ No ☐**	______
Diabetes	**Yes ☐ No ☐**	______
Cancer	**Yes ☐ No ☐**	______
Heart Disease	**Yes ☐ No ☐**	______
High Blood Pressure	**Yes ☐ No ☐**	______
Kidney Disease	**Yes ☐ No ☐**	______
Lupus	**Yes ☐ No ☐**	______
Thyroid Disease	**Yes ☐ No ☐**	______

5) SOCIAL HISTORY

Do you drive? **Yes ☐ No ☐**
Any visual difficulties? **Yes ☐ No ☐**
If *yes* please explain______
Do you use tobacco/e-cigarette? **Yes ☐ No ☐** **If *yes*, what type/ amount/ how long? ______**
Do you use illegal drugs **Yes ☐ No ☐** **If *yes*, what type/ amount/ how long? ______**
Do you drink alcohol? **Yes ☐ No ☐** **If *yes*, how often?______**
Have you ever been exposed to or infected with any sexual transmitted diseases/ HIV? **Yes ☐ No ☐**

6) REVIEW OF SYMPTOMS (Do you currently have the following):

CONSTITUTIONAL
- **Fever** **Yes ☐ No ☐**
- **Weight Loss** **Yes ☐ No ☐**
- **Weight Gain** **Yes ☐ No ☐**

CARDIOVASCULAR/VASCULAR
- **Heart Condition** **Yes ☐ No ☐**
- **High Blood Pressure** **Yes ☐ No ☐**
- **Vascular Disease** **Yes ☐ No ☐**

EAR, NOSE, MOUTH, THROAT
- **Allergies/ Hay Fever** **Yes ☐ No ☐**
- **Chronic Cough** **Yes ☐ No ☐**
- **Dry Mouth** **Yes ☐ No ☐**
- **Ear Infection** **Yes ☐ No ☐**
- **Sinus Congestion** **Yes ☐ No ☐**

RESPIRATORY
- **Asthma** **Yes ☐ No ☐**
- **Bronchitis** **Yes ☐ No ☐**
- **Emphysema** **Yes ☐ No ☐**

GASTROINTESTIONAL
- **Constipation** **Yes ☐ No ☐**
- **Diarrhea** **Yes ☐ No ☐**

GENITOURINARY
- **Bladder** **Yes ☐ No ☐**
- **Kidney** **Yes ☐ No ☐**

MUSCULOSKELETAL
- **Arthritis/Rheumatoid** **Yes ☐ No ☐**
- **Osteoarthritis** **Yes ☐ No ☐**
- **Muscle/Joint Pain** **Yes ☐ No ☐**

INTEGUMENTARY (Skin)
- **PXE (Pseudoxanthoma Elasti)** **Yes ☐ No ☐**

NEUROLOGICAL
- **Headache** **Yes ☐ No ☐**
- **Migraine** **Yes ☐ No ☐**
- **Seizures** **Yes ☐ No ☐**

PSYCHIATRIC **Yes ☐ No ☐**

ENDOCRINE
- **Diabetes** **Yes ☐ No ☐**

If *yes*, your most recent blood sugar level? _______
- **Thyroid/ Other Glands** **Yes ☐ No ☐**

HEMATOLOGIC/LYMPHATIC
- **Anemia** **Yes ☐ No ☐**
- **Bleeding Problems** **Yes ☐ No ☐**

IMMUNOLOGY
- **Syphilis** **Yes ☐ No ☐**
- **Hepatitis** **Yes ☐ No ☐**

ALLERGIES **Yes ☐ No ☐**

☐ **Medical Eye Exam to detect/rule out ocular and retinal diseases is recommended on annual basis through dilated fundus exam (DFE), photos, visual field testings (VF) or OCT scan. These elective services might not be covered/partially covered by your medical insurance.**

☐ **Reschedule to a later date** **Consent for ☐ DFE ☐ VF ☐ Photos ☐ OCT Scan ☐ Medical Eye Exam**

Patient/Guardian Signature:______ Date: ______/______/______