Liberty Hill Eye Associates, PLLC
Dr. Jim Hannigan

THE FOLLOWING WILL ASSIST THE DOCTOR IN YOUR EXAMINATION

Date: _____ **New** **Update**

Please print

Legal Last Name	Legal First Name	MI	Nickname

Street Address	Apt #	City, State	Zip

Email Address:

☐ Married ☐ Single ☐ Divorced

Gender	Date of Birth	Social Security	Day Phone	Home Phone

Place of Employment	Occupation

Referred by: ☐ **Patient** _____ ☐ **Doctor** _____ ☐ **Yellow Pages** ☐ **Newspaper**

In case of emergency, contact: Name: _____ Day Phone: _____

If minor, who is responsible for the account? Name _____

Address _____ Phone _____

Name of Primary on Insurance: _____ S.S. # _____

Medical Insurance Name: _____ ID# _____ Grp # _____

Vision Insurance Name: _____ ID# _____ Grp # _____

OCULAR HISTORY

Last Eye Exam? _____ by Dr. _____
Reason for today's exam:
_____

Do you wear glasses?	N	Y
Do you wear contact?	N	Y
Are you interested in contact lenses?	N	Y
With correction, are you having blurry vision at far	N	Y
With correction, are you having blurry vision at near	N	Y
Do you get headaches?	N	Y

Do you ever see double? ..... N Y
Do your eyes itch/burn/water? ..... N Y
Are you sensitive to bright light? ..... N Y
Do you use a computer? ..... N Y hours per day? ___

MEDICAL HISTORY

List any prescription or over-the-counter medications being taken:
_____
_____
_
Do you use eye drops? ..... N Y
Are you allergic to any medications? ..... N Y
If yes, please list:
_____
Do you have seasonal/environmental/other allergies? ..... N Y
Please check if you or any blood relatives (BR) have any of the following conditions:

	SELF	BR	STATE RELATIONSHIP
Cataract	☐	☐	_____
Glaucoma	☐	☐	_____
Lazy Eye/Crossed Eyes	☐	☐	_____
Macular/Retinal degeneration	☐	☐	_____
Eye surgery/ Trauma/ Retinal detachment	☐	☐	_____
Diabetes	☐	☐	_____
High or low blood pressure	☐	☐	_____
Thyroid problems	☐	☐	_____
High Cholesterol/ Heart Disease	☐	☐	_____

I have the following diseases/ disorders:
- ❒ Arthritis/ Joint
- ❒ Blood
- ❒ Cancer/ Tumors
- ❒ Digestive
- ❒ HIV positive
- ❒ Infection/Cold
- ❒ Kidney
- ❒ Liver
- ❒ Neurologic disorders
- ❒ Psychiatric
- ❒ Respiratory/ Lung
- ❒ Seizures
- ❒ Sinus
- ❒ Skin
- ❒ Stroke/ Brain injury
- ❒ Urogenital/ Sexually Transmitted Disease
- ❒ Other:

_____

To the best of my knowledge, I have checked all of the preceding disorders pertaining to me. If I have any changes in my health or medications, I shall inform the doctor/staff at my next appointment.

_____ Date _____
Patient Signature (Parent or Guardian)

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HISTORY UPDATE

I have read my history form dated _____ and confirm that it adequately states past and present conditions. Please notify the staff if there have been changes.