Dilation: greatly helps the doctor check for important diseases. There is no additional cost for dilation to you on the day of your examination. You will still be able to drive. If you **do not** wish to have this performed today, initial here *__________*

Have you had:

CATARACT SURGERY	YES NO	EYE MUSCLE SURGERY	YES NO	LASIK/PRK SURGERY	YES NO
RETINAL SURGERY	YES NO	TRAUMATIC EYE INJUR	YES NO	EYE INFECTIONS	YES NO

Your current medical history: Circle all that apply.

High Cholesterol	YES	NO	Herpes Simplex/Zoster	YES	NO
Heart Disease	YES	NO	HIV Positive	YES	NO
High Blood Pressure	YES	NO	Sarcoidosis	YES	NO
Weight Gain/Loss	YES	NO	Lupus	YES	NO
Sinus Problems	YES	NO	Arthritis	YES	NO
Diabetes	YES	NO, how long? ____________	Osteoporosis	YES	NO
Most recent blood sugar level ______________			Migraines (diagnosed)	YES	NO
Most recent A1c level ______________			Seizures	YES	NO
Thyroid Disease	YES	NO	ADD or ADHD	YES	NO
Crohn's Disease	YES	NO	Anxiety disorder	YES	NO
Hepatitis	YES	NO	Depression/Bipolar	YES	NO
Kidney stones or disease	YES	NO	Asthma	YES	NO
Sexually Transm. Disease	YES	NO	COPD	YES	NO
Anemia, Leukemia	YES	NO	Cancer (type ____________)	YES	NO

LIST ALL CURRENT MEDICATIONS:

Do you or anyone in your immediate family have:

			RELATION
Amblyopia/Lazy Eye	YES	NO	________________
Glaucoma	YES	NO	________________
Macular Degeneration	YES	NO	________________
Diabetes	YES	NO	________________
High Blood Pressure	YES	NO	________________
Heart Disease	YES	NO	________________
High Cholesterol	YES	NO	________________
Breast Cancer	YES	NO	________________
Brain Tumors	YES	NO	________________

Other Disease ________________________________

SOCIAL HISTORY

Do you smoke NO YES; _________ packs per day

Alcohol Use NO YES; _________ drinks per week

FEMALES: Are you pregnant? NO YES ___ weeks

Allergies: Animal Dander YES NO

Environmental YES NO

Drug Allergies: (list any)

Authorization: I authorize any holder of medical or other information about me to release any information needed for this claim to be Social Security Administration and Health Care Financial Administration, its intermediaries or carriers, the billing agent of the supplier, Medicaid, an Insurance Company, or third party payor. I understand that I am responsible for amounts, deductibles, and charges not reimbursed by Medicare, Medicaid, my insurance company, or a third party payor. I permit a copy of this authorization to be used in place of the original signature and request payment of medical insurance benefits be paid by Dr. Gary Shepard, PC.

Advance Beneficiary Notice: I further understand that Medicare does not pay for a Refraction (code 92015); and Medicaid, Medicare, and Tricare do NOT pay for contact lens fittings (code 92310). **Privacy Notice:** I have been offered a copy of the office's privacy notice or have read a copy that is on display.

Signature: ____ Date: ___________________________