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

** _____ **

Have you had:

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

YOUR current medical history: Circle all that apply.

High Blood Pressure	YES NO	Herpes Simplex/Zoster	YES NO
High Cholesterol	YES NO	HIV Positive/AIDS	YES NO
Heart Disease/Attack(s)	YES NO	Sarcoidosis	YES NO
Stroke(s)	YES NO	Arthritis	YES NO
Weight Gain/Loss	YES NO	Lupus	YES NO
Diabetes	**YES NO, how long?** _____	Osteoporosis	YES NO
Most recent blood sugar level _____		Migraines	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	COPD	YES NO
Anemia or Leukemia	YES NO	Cancer (type) _____	YES NO
Multiple Sclerosis	YES NO	**Other** _____	YES NO

*****PLEASE LIST ALL CURRENT MEDICATIONS***:**

Do you or anyone in your immediate family have:

			RELATION
Glaucoma	YES	NO	_____
Macular Degeneration	YES	NO	_____
Diabetes	YES	NO	_____
Breast Cancer	YES	NO	_____
Heart Disease	YES	NO	_____

SOCIAL HISTORY

Do you smoke? NO YES; __ packs per day

Alcohol Use NO YES; __ drinks – week

Females: are you pregnant? NO YES wks

Allergies: Animal Dander/pollen YES NO

Drug Allergies: _____

Authorization: I authorize any holder of medical or other information about me to release any information needed for this claim to the 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 the 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: _____