HILLTOP EYECARE PLLC

Patient History

Dr. Jacob Moll
Dr. Megan Moll
Optometric Physicians

Patient's Name _____ **Birthdate:** _____

Mailing Address: _____

_____

(City) (State) (Zip Code)

Parent/Guardian: _____

(if patient is a minor)

Home Phone #: (___)_____ **Work/Cell Phone #:** (___)_____

Email Address_____

How did you hear about us? (circle) Sign Location Web Site Insurance Yellow Pages

Magazine Doctor Referral Friend/Relative_____

Do you have vision insurance? Y N **Do you have health insurance ? Y N**

If yes, please fill out your card information on the next page (backside) and leave a copy of your card(s) with the receptionist.

Date of last eye examination: _____ **Doctor:** _____

Family Doctor: _____**Date of last visit:**_____

Do you currently wear: glasses? Y N contact lenses? Y N

Have you (or family) had the following?	*Self*	*Family*
Amblyopia (lazy eye)	☐	☐
Macular Degeneration	☐	☐
Glaucoma	☐	☐
Diabetic Retinopathy	☐	☐
Retinal Detachment	☐	☐
Retinal Disease	☐	☐
Blindness	☐	☐

Have you had eye surgery for the following?	
Cataract	☐
Trauma	☐
Laser Vision Correction	☐
Foreign Body Removal	☐
Retinal Detachment	☐
Other _____	

List any *MEDICATIONS* you are taking (eye drops & over the counter)

_____

_____

Are you allergic to any medications? Y N please list: _____

Are you pregnant and/or nursing at this time? Y N

Do you drive: Y N If yes, do you have visual difficulty when driving? Y N

Do you use tobacco products? Y N Type/amount/how long: _____

Do you drink alcohol? Y N Type/amount/how long: _____

I hereby declare that the above information is true to the best of my knowledge.

Patient (or guardian) Signature _____ **Date** _____

Doctor Initial_____**Date**_____**Doctor Initial**_____**Date**_____

Review of Systems:

(Check all that apply)

Eyes (Ocular symptoms)	**YES**
Eye pain or soreness	☐
Fatigue/tired eyes	☐
Dry/gritty feeling	☐
Redness	☐
Burning	☐
Itching	☐
Excess watering	☐
Mucous discharge	☐
Chronic infections	☐
Squinting	☐
Glare light sensitivity	☐
Halos around lights	☐
Double vision	☐
Loss of vision	☐
Blurred vision	☐
Flashes/floaters	☐
Constitutional	
Fever	☐
Weight loss or gain	☐
Skin	
Rosacea	☐
Metal allergies	☐
Ear, Nose, Throat, Mouth	
Allergies/hay fever	☐
Sinus infections	☐
Hearing loss	☐
Respiratory	
Asthma	☐
Chronic bronchitis	☐
Emphysema	☐
Vascular/Cardiovascular	
Heart disease/problems	☐
High blood pressure	☐
Stroke	☐
Gastrointestinal	
Acid Reflux	☐
Intestinal Problems	☐
Liver/spleen problems	☐
Endocrine	
Thyroid/other glands	☐
Diabetes	☐
Genitourinary	
Genitals/kidney/bladder	☐
Lymphatic/hematologic	
Anemia	☐
Bleeding disorders	☐
Bones/joints/muscles	
Rheumatoid arthritis	☐
Neurological	
Headaches/migraines	☐
Seizures	☐
Multiple Sclerosis	☐
Alzheimer's/dementia	☐
Parkinson's	☐
Cancer	☐
Type: _____	
Psychiatric	☐
Immune system	☐