

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:						
				<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> 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:

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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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye/Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular/Retinal degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye surgery/ Trauma/ Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol/ Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

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.

\_\_\_\_\_  
**Patient Signature** (Parent or Guardian) Date \_\_\_\_\_

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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.