



**DANIEL F. GOODMAN, M.D.**

**EYE HISTORY:**

PLEASE STATE THE MAIN PROBLEM WITH YOUR EYES: \_\_\_\_\_

WHEN DID THIS PROBLEM START? RIGHT EYE \_\_\_\_\_ LEFT EYE \_\_\_\_\_

CURRENT EYE MEDICATIONS:

NAME                      DOSE                      HOW OFTEN?                      HOW LONG HAVE YOU BEEN USING THIS?

WHICH EYE (IF EITHER) DO YOU FEEL IS "DOMINANT" (WHICH EYE DO YOU USE TO SHOOT A CAMERA?)

RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_

WHEN WAS YOUR FIRST EYE OR VISION EXAM AND WHY WERE YOU SEEN? \_\_\_\_\_

DO YOU WEAR CONTACT LENSES? \_\_\_\_\_ FOR HOW LONG? \_\_\_\_\_ LAST REPLACED \_\_\_\_\_

TYPE OF LENSES WORN: SOFT \_\_\_\_\_ HARD \_\_\_\_\_ DAILY WEAR \_\_\_\_\_ EXTENDED WEAR \_\_\_\_\_ DISPOSABLE \_\_\_\_\_

WHEN WAS THE LAST DAY (DATE) THAT YOU WORE YOUR CONTACT LENSES? \_\_\_\_\_

WHEN DID YOU GET YOUR FIRST GLASSES AND WHAT WERE THEY FOR? \_\_\_\_\_

WHEN WERE YOUR GLASSES LAST CHANGED? \_\_\_\_\_

WHEN DID YOU GET YOUR FIRST BIFOCALS? \_\_\_\_\_

WHEN WAS YOUR LAST VISIT TO YOUR EYE DOCTOR PRIOR TO YOUR PRESENT PROBLEM? \_\_\_\_\_

HAVE YOU EVER HAD ANY OTHER EYE PHYSICIANS? IF SO, THEN PLEASE LIST NAME(S) OF THE MOST RECENT: \_\_\_\_\_

DO YOU HAVE, OR HAVE YOU EVER HAD: (Circle Yes or No)

Yes	No	BLURRED OR REDUCED VISION?	Yes	No	NIGHT TIME DIFFICULTIES
Yes	No	KELOID FORMATION?			GLARE OR HALOES?
Yes	No	ANY EYE INFECTIONS?	Yes	No	EYE PAIN?
Yes	No	ANY EYE INJURY?	Yes	No	ANY EYE SURGERY?
Yes	No	FOREIGN BODY IN EYE?	Yes	No	GLAUCOMA?
Yes	No	ANY EYE DROPS OR MEDICATIONS?	Yes	No	OTHER EYE PROBLEMS?

HAVE YOU EVER WORN "MONOVISION" CONTACT LENSES? \_\_\_\_\_ (NEAR VISION \_\_\_\_\_ EYE)

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**MEDICAL HISTORY:**

DO YOU HAVE ANY ILLNESSES? (HIGH BLOOD PRESSURE, DIABETES, ARTHRITIS, HEART DISEASE, BRONCHITIS, ASTHMA, ETC.) \_\_\_\_\_

LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICINES:

<u>NAME</u>	<u>HOW MUCH?</u>	<u>HOW OFTEN?</u>	<u>HOW LONG?</u>	<u>WHAT FOR?</u>

ARE YOU ALLERGIC TO ANY MEDICINES (IF SO, PLEASE LIST) \_\_\_\_\_

HAVE YOU EVER HAD COSMETIC/PLASTIC SURGERY? (IF SO, LIST TYPE) \_\_\_\_\_

EVER SMOKE? \_\_\_\_\_ HOW MUCH? \_\_\_\_\_ ALCOHOL INTAKE? \_\_\_\_\_

SPECIAL DIET? \_\_\_\_\_

WHERE WERE YOU BORN AND RAISED? \_\_\_\_\_

LIST CHRONOLOGICALLY ALL HOSPITALIZATION AND/OR OPERATIONS YOU HAVE HAD:

<u>DATE</u>	<u>PURPOSE OF HOSPITALIZATION OR TYPE OF OPERATION</u>

DO YOU HAVE, OR HAVE YOU EVER HAD: (Circle Yes or No)

Yes	No	ANY OTHER ALLERGIES?	Yes	No	DIGESTIVE PROBLEMS?
Yes	No	ASTHMA?	Yes	No	ULCERS?
Yes	No	HAY FEVER?	Yes	No	KIDNEY PROBLEMS?
Yes	No	HIGH BLOOD PRESSURE?	Yes	No	GENITOURINARY PROBLEMS?
Yes	No	ARTHRITIS?	Yes	No	SKIN PROBLEMS?
Yes	No	HEART PROBLEMS?	Yes	No	ANEMIA?
Yes	No	BREATHING PROBLEMS?	Yes	No	BLOOD PROBLEMS?
Yes	No	ANKLE SWELLING?	Yes	No	STROKE?
Yes	No	TUBERCULOSIS?	Yes	No	VENEREAL DISEASE?
Yes	No	TUMOR OR CANCER?	Yes	No	LIVER PROBLEMS?
Yes	No	SERIOUS INJURY?	Yes	No	STEROIDS OR
Yes	No	HORMONAL PROBLEMS?			ANTICOAGULANTS?
Yes	No	ARE YOU PREGNANT OR NURSING?	Yes	No	HIV POSITIVE?
Yes	No	KELOID FORMATION?	Yes	No	HEPATITIS POSITIVE?
Yes	No	ANY SERIOUS ILLNESSES, DISEASE, OR CONDITIONS NOT MENTIONED? PLEASE DETAIL:			

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**MEDICAL HISTORY (PAGE 2)**

NAME YOUR OTHER PHYSICIANS AND WHY YOU SEE THEM: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WHEN WAS YOUR LAST VISIT TO YOUR GENERAL PHYSICIAN, AND WHAT WAS IT FOR?

\_\_\_\_\_

\_\_\_\_\_

WHAT WERE THE DOCTOR'S FINDINGS?

\_\_\_\_\_

\_\_\_\_\_

WHAT IS THE GENERAL STATE OF YOUR HEALTH?

\_\_\_\_\_

\_\_\_\_\_

FAMILY HISTORY: HAS ANYONE IN YOUR FAMILY EVER HAD: (Circle Yes or No)

Yes	No	CATARACT?	Yes	No	ANY EYE OPERATION?
Yes	No	GLAUCOMA?	Yes	No	MACULAR PROBLEMS?
Yes	No	RETINAL DETACHMENTS?	Yes	No	OTHER FAMILY EYE PROBLEMS?
Yes	No	BLINDNESS?	Yes	No	DIABETES?
Yes	No	CANCER?	Yes	No	HIGH BLOOD PRESSURE?
Yes	No	DID YOUR PARENTS SEE WELL?	Yes	No	ANY HEREDITARY OR FAMILIAL DISEASES OR CONDITIONS?

IS THERE ANYTHING ELSE YOU FEEL IS IMPORTANT ABOUT YOU, YOUR HEALTH, OR YOUR EYES?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

THANK YOU

**Daniel F. Goodman, M.D.**

**PATIENT'S NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Payment is due at the time of service. Persons who carry medical insurance should remember that professional services are rendered and charged to the patient and not the insurance company. We will gladly assist you in preparing necessary forms to expedite your insurance claims.

I hereby request that payment of authorized Medicare benefits, or any other insurance that I have, be made on my behalf to Daniel F. Goodman, M.D. for any services furnished me by this physician/provider. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents or any other insurance company any information needed to determine these benefits or the benefits payable for related services. **I ALSO AGREE TO PAY FOR ALL "NON-COVERED SERVICES", INCLUDING REFRACTIONS AND CONTACT LENS RELATED SERVICES.**

I have been informed that my insurance company may not cover refractions (CPT 92015) in which case I agree to be fully responsible for the charge of **\$50.00**.

In addition, I consent to evaluation and treatment as necessary for care, including but not restricted to whatever drugs or studies that may be used by Daniel F Goodman, M.D., or qualified designate.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as an original.

**SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_

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