



## Hearing Health History

Do you ever experience feelings of dizziness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have difficulty hearing women or young children?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have ringing or other noises in your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have trouble knowing where sounds are coming from?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do others complain that you watch TV with the volume too high?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you unable to understand when someone talks to you from another room?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you frequently have to ask others to repeat themselves?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have others told you that you don't seem to hear them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty understanding when in groups or in noisy situations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you avoid family meetings or social situations because you "can't understand"?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have to sit up front in meetings or in church in order to understand?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

## General Health History

Family Physician's Name _____				Date of Last Visit _____			
<b>yourself</b>		<b>family members</b>		<b>yourself</b>		<b>family members</b>	
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Type ____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chem. Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Alcohol Use	<input type="checkbox"/> Yes <input type="checkbox"/> No			

### Medications

### Allergies


## Medicare/Medicaid Authorization

I certify that the information given by me in applying for payment is correct. I authorize release authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**TREATMENT CONSENT:** I authorize LaHaye Total Eye Care, its staff, and doctors to furnish the routine diagnostic and therapeutic procedures that are deemed necessary for the patient whose name appears on this form.

Knowing that I am suffering from a condition requiring outpatient care, I do hereby voluntarily consent to such outpatient care encompassing routine diagnostic procedures and medical treatment by the attending physician, his assistants or designees as necessary in his judgment. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me regarding treatments or examinations in the Outpatient Surgery Center.

I understand that the attending physician is not an agent or employee of the LaHaye Total Eye Care, but he has been granted privileges by the LaHaye Total Eye Care to practice medicine and to use the facilities of the outpatient surgery center. I further understand that the nurses and other technical staff at this outpatient center do not practice medicine, but carry out the orders of independent licensed physicians when providing treatment to patients at this outpatient surgery center.

During the course of your eye examination, it may become either necessary or advisable to dilate your eyes, to optimize the examination. We recommend that if your eyes are dilated in connection with your eye examination, that you refrain from driving. You should either arrange to have someone such as a relative or a friend drive you. While we do provide disposable sunglasses for your comfort and convenience, we do not recommend driving with dilated eyes; and, we do not imply by providing sunglasses that driving is safe or should be attempted after dilation of your eyes. If you have any questions about our recommendations regarding driving or any other activity after your eyes have been dilated, you may ask anyone with our staff, and we will answer your questions.

**ACKNOWLEDGEMENT:** I have read the above recommendations, and understand them fully. I further understand that I may ask any staff member of LaHaye Total Eye Care for additional information or for further explanation. I understand that it is recommended that I refrain from driving after dilation of my eyes. This form has been fully explained to me, I understand its contents.

**Do you have a living will or advanced directives?**  YES  NO If yes, please explain: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Guarantor Signature \_\_\_\_\_

Witness to Signature \_\_\_\_\_ Date \_\_\_\_\_ Authorized Person-Relationship \_\_\_\_\_