

Diane Serex-Dougan, O.D., FCOVD  
Behavioral Optometry and Vision Therapy  
Adult History Form

**I am pleased to welcome you to my practice. Please complete this questionnaire before your appointment.**

**Full Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Home Address** \_\_\_\_\_

**Home telephone** \_\_\_\_\_ **other telephone** \_\_\_\_\_

**Occupation** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Single**     **Married**     **Widowed**     **Separated**     **Divorced**

**Present Situation:** What has occurred that leads you to request a visual evaluation?

\_\_\_\_\_

**Have you noticed any unusual signs or symptoms that concern you?**

\_\_\_\_\_

**Do you use a computer?** \_\_\_\_\_ **Number hours/day?** \_\_\_\_\_

**Date of last eye exam** \_\_\_\_\_ **Name of doctor** \_\_\_\_\_

**Do you wear glasses?**  **Yes**  **No**  **all the time**  **reading**  **driving/TV**

**Do you wear contact lenses**  **Yes**  **No** **Any problems?** \_\_\_\_\_

**Health History:** Check any conditions that apply to you or your family

Allergies	___self	___family	Lazy Eye	___self	___family
Diabetes	___self	___family	Turned Eye	___self	___family
Heart Problem	___self	___family	Light Sensitive	___self	___family
Head trauma	___self	___family	Eyestrain	___self	___family
Headaches	___self	___family	Dry Eyes	___self	___family
Migraines	___self	___family	Floaters/spots	___self	___family
Blindness	___self	___family	Flashing lights	___self	___family
Thyroid	___self	___family	Cataracts	___self	___family
High Blood Pressure	___self	___family	Glaucoma	___self	___family
Breathing Difficulty	___self	___family	Eye surgery	___self	___family
AIDS/HIV+	___self	___family	Arthritis	___self	___family
Artificial Heart Valve	___self	___family	Artificial joints	___self	___family
Asthma	___self	___family	Cancer	___self	___family
Hepatitis	___self	___family	Skin Problems	___self	___family

Name of Physician \_\_\_\_\_ Date of last physical \_\_\_\_\_

Name of medication taken \_\_\_\_\_

Name of medicines that you are allergic to \_\_\_\_\_

**Other:**

Recreational activities/sports \_\_\_\_\_

Number of hours/day watching television \_\_\_\_\_

Is there any other information about you that you think is important? \_\_\_\_\_

**Insurance Information:**

Suscriber name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group Number \_\_\_\_\_

Birthdate \_\_\_\_\_ Policy Number \_\_\_\_\_

**I, the undersigned acknowledge my financial responsibility. I understand that all fees are due at time of service unless otherwise arranged with Dr. Serex-Dougan. Dr. Serex-Dougan will provide necessary forms for insurance submittal. I am responsible for filing for insurance reimbursement.**

\_\_\_\_\_  
signed

\_\_\_\_\_  
date

***Privacy Practice***

***By law, you are to be given notice of my privacy practices. This notice describes how I/we protect your health information and what rights you have regarding it. If you wish to review such notice, I will gladly supply you with a copy to either take with you or to review while you are here.***

***I have received the NOTICE OR PRIVACY PRACTICES and I have been provided an opportunity to review it.***

\_\_\_\_\_  
signed

\_\_\_\_\_  
date of birth

\_\_\_\_\_  
date

**Thank you very much for your time and effort in filling out this form.**