GOLEBIOWSKI
EYE CARE, LLC

Welcome to Golebiowski Eye Care, the office of Holly Golebiowski, O.D. Doctor of Optometry

Patient Information

First Name_____Last Name_____
Address_____
City_____State_____Zip Code_____
DOB (mm/dd/yyyy)____/____/_____SSN#_____/_____/_____
Gender: Male ☐ Female ☐ Preferred # Home ☐ Work ☐ Cell ☐
Home Phone_____Cell_____
Work _____Email_____

Insurance Information

Do you have vision insurance? Yes ☐ No ☐
If yes, insurance carrier_____
Insurance subscriber_____DOB__/__/____
Subscriber ID or SSN#_____
Do you have health insurane? Yes ☐ No ☐
If yes, insurance carrier_____
Insurance subscriber_____DOB__/__/____
Subscriber ID or SSN#_____

Is the reason for visit today a result of an accident at work? Yes ☐ No ☐ If yes, claim number_____

Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions?

	Yes	No
Constitutional		
Developmental Disabilities	☐	☐
Cancer	☐	☐
Fatigue Syndrome	☐	☐
Other_____		
Ears/Nose/Mouth/Throat		
Hearing Loss	☐	☐
Sinusitis	☐	☐
Dry Mouth	☐	☐
Laryngitis	☐	☐
Other_____		
Neurological		
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Celebral Palsy	☐	☐
Tumor	☐	☐
Stroke/CVA	☐	☐
Migraine	☐	☐
Autism Spectrum Disorder	☐	☐
Other_____		
Psychiatric		
Depression	☐	☐
Attention Deficit	☐	☐
Anxiety Disorder	☐	☐
Bipolar Disorder	☐	☐
Other_____		

	Yes	No
Cardiovascular		
Hypertension	☐	☐
Stroke/CVA	☐	☐
Heart Disease	☐	☐
Congestive Heart Failure	☐	☐
Other_____		
Respiratory		
Cigarette Smoker	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Chronic Obstruction	☐	☐
Sleep Apnea	☐	☐
Other_____		
Gastrointestinal		
Crohn's	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Acid Reflex	☐	☐
Celiac Disease	☐	☐
Other_____		

	Yes	No
Genito-urinary		
Kidney disease	☐	☐
Prostate disease/cancer	☐	☐
STD - herpetic/chlamydia	☐	☐
Benign Prostate Hypertrophy	☐	☐
Pregnant	☐	☐
Nursing	☐	☐
Herpes	☐	☐
Chlamydia	☐	☐
Other_____		
Musculoskeletal		
Osteoarthritis	☐	☐
Arthritis	☐	☐
Fibromayalgia	☐	☐
Muscular Dystrophy	☐	☐
Ankylosing Spondylitis	☐	☐
Osteoporosis	☐	☐
Gout	☐	☐
Other_____		
Integumentary		
Eczema	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Herpes Simplex/ Cold Sores	☐	☐
Herpes Zoster/ Shingles	☐	☐
Other_____		

	Yes	No
Endocrine		
Type 1 Diabetes Mellitus	☐	☐
Year of diagnosis_____		
Value of last A1C_____		
Type 2 Diabetes Mellitus	☐	☐
Year of diagnosis_____		
Value of last A1C_____		
Thyroid dysfunction	☐	☐
Hormonal dysfunction	☐	☐
Other_____		
Hemotologic/Lymphatic		
Anemia	☐	☐
Large-volume blood loss	☐	☐
Ulcer	☐	☐
Hypercholesteremia	☐	☐
Other_____		
Allergic/Immune		
Drug Allergies	☐	☐
Environmental Allergies	☐	☐
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
Sjogren's Syndrome	☐	☐
Other_____		

Primary Care Physician

Full Name_____
Phone Number_____
Address_____
City_____State_____Zip Code_____

Medications

No Medications ☐

List all **CURRENT** prescriptions, over-the-counter prescription, eye drops and dosages for each.

_____
_____
_____
_____

Patient Initial_____ Review Date_____Dr. Initial_____
Patient Initial_____ Review Date_____Dr. Initial_____
Patient Initial_____ Review Date_____Dr. Initial_____

Allergies to Medications

No Allergies to Medications ☐

List any allergies you might have and the associated reaction.

_____
_____
_____

Other Allergies

No Other Allergies ☐

List any allergies you might have and the associated reaction.

_____
_____
_____

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Patient Ocular History

	Yes	No		Yes	No
Glaucoma	☐	☐	Strabismus	☐	☐
Glaucoma Suspect	☐	☐	Amblyopia	☐	☐
Cataract	☐	☐	Retinal Degeneration/Hole/Detachment	☐	☐
Age-related Macular Degeneration	☐	☐	Keratoconus	☐	☐
Surgery	☐	☐	Injury	☐	☐
Patching	☐	☐	Dry Eye	☐	☐
Inflammatory Disorder	☐	☐	Nystagmus	☐	☐

Other_____

Social History

Are you a drug user? Yes☐ No☐

Are you a: Non-drinker ☐ Social Drinker ☐

Tobacco Use (mark which one applies)

Heavy tobacco smoker ☐ Light tobacco smoker☐

Never a smoker ☐ Former Smoker ☐

Other_____

Family Medical History

	Yes	No	Relationship
Cancer	☐	☐	_____
Type 1 Diabetes Mellitus	☐	☐	_____
Type 2 Diabetes Mellitus	☐	☐	_____
Hypertension	☐	☐	_____
Hyperthyroidism	☐	☐	_____
Hypothyroidism	☐	☐	_____
Other_____			_____

Family Ocular History

	Yes	No	Relationship
Cataract	☐	☐	_____
Degenerative disorder of macula	☐	☐	_____
Glaucoma	☐	☐	_____
Amblyopia (Lazy eye)	☐	☐	_____
Strabismus (cross eyes)	☐	☐	_____
Blindness	☐	☐	_____
Other_____			_____

Contact Lens History

Lens Type: Soft ☐ RGP/hard lens☐ Hybrid☐

Contact Lens Brand_____

Contact Lens Rx OD_____

O S_____

How many hours a day do you wear your contacts? _____

How often do you replace your contacts? Daily☐ Bi-weekly☐ Monthy☐ Other _____

Do you wear your contacts overnight? Yes☐ No☐

What solution do you use to clean your contacts? _____

Please list all major surgeries or injuries you have had in the past.

_____

_____

_____

Authorization & Release of Benefits

I hereby authorize direct payment of benefits to Golebiowski Eye Care, LLC for services rendered by the providers. I also authorize the release of any medical information that may be required in determination of such benefits. I understand that some services may require approval of my primary care physician for coverage and that, if I do not obtain approval, I am financially liable for the services. I understand that I an financially responsible for any balance not covered by my insurance, including co-pays, deductibles, refractions, diagnostic testing, and products purchased such as glasses and contact lenses.

Signature of Responsible Party_____Date_____

I acknowledge that I received a copy of Golebiowski Eye Care, LLC "HIPAA Notice of Privacy Practices".

Signature of Responsible Party_____Date_____