Head to Toe Healthcare, PLC®
Advanced Eye and Foot Care
Optometrist & Podiatrist

7406 N. La Cholla Blvd. Tucson, Arizona 85741
p: (520) 545-0202 f: (520) 545-0201
www.headtotoehealthcare.org

Contact Lens Policy

Warning: If you are having any unexplained eye discomfort, watering, vision change/or redness, remove your lenses immediately and consult your eye care practitioner before wearing your lenses again.

Contact lens trials that are dispensed REQUIRE a contact lens follow-up before contact lens prescription can be finalized; unless it has been verified that patient has been wearing the same contact lens previously. Patient needs to have the contact lens in for a minimum of 2 hours before the appointment to ensure proper contact lens follow-up evaluation. This follow-up needs to be WITHIN 30 DAYS of the initial contact lens dispensed. AFTER 30 DAYS, patient will be responsible for an office visit fee.

It is considered another contact lens fitting if any changes requested be made to a FINALIZED H2T contact lens Rx. (Changing brands or colors)

If contact lens supply is ordered through H2T office, exchanges are only granted to UNOPENED and UNMARKED boxes. If contact lens supply is ordered elsewhere, H2T will not offer any exchanges.

Glasses/ Frame Policy

ANY H2T prescription sunglasses or glasses will have a 30 DAYS adaptation period. WITHIN 30 DAYS OF THE EXAM DATE, patient is responsible for scheduling a glasses follow-up appointment if he/she is having problems with their prescription. AFTER the 30 DAYS, there will be an office visit fee for a prescription recheck. There will be a charge for verification of glasses purchases elsewhere with H2T prescription.

NO RETURNS are granted once a purchase is made. There are NO EXCHANGES for any purchased non-prescription glasses, sunglasses or accesorries.

H2T is not responsible for any scratched, chipped or broken frame that is not considered a manufacturer defect. Lenses or frames will be sent out for verification. There will be a fee to have the lenses or frames replaced.

If patient prefers to provide a frame and have H2T fit lenses to the frame, H2T is NOT RESPONSIBLE for any damages to the frame.

H2T is not liable for any frame adjustments that is not purchased through H2T. This is a PAID service and H2T are NOT LIABLE for any damages or scratches that could happen during this service.

No Show/ Cancellation Policy

ALL scheduled no show appointments will be charged $30.00 no show fee. Patient is responsible to CALL the office to reschedule or cancel any appointment at least 24 hours in advance.

Patient who is running 20 minutes late for his/her scheduled appointment will be rescheduled to the next available appointment/ day.

H2T Office Policy

Photo ID required for insurance and physical address verification. Vision or Medical cards are required at the time of service for continuation of care. Patient is responsible to notify H2T any insurance changes. Any unverified insurance information will result in the visit being a self-pay visit.

H2T DOES NOT participate with any workman's compensation companies.

I, _____, have read and understand the policies stated above.

Signature_____ Date: _____

Rev Nov 2015

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OPTOMETRY MEDICAL HISTORY QUESTIONNAIRE

Name:_____ **Guardian (If applicable):**_____
Address:_____ **Today's Date:**_____/_____/_____
City:_____ **State:**_____ **Zip:**_____ **Home Phone:** _____-_____-_____
Birth Date:____/____/____ **Social Security (opt):**_____ **Email:** _____
Occupation:_____ **Employer:**_____ **Work Phone:** _____-_____-_____
Primary Care Physician:_____ **Cell Phone:** _____-_____-_____
PCP Address:_____ **Last Medical Exam:**_____
Previous Eye Physician:_____ **Last Eye Exam:**_____
How did you hear about us?_____

☐ **Was the HIPPA – Notice of Privacy Practices form made available to you? _____(Please initial)**

1) EYE CHIEF COMPLAINT (TODAY)

Blurred Vision	**Yes ☐ No ☐**	**Foreign Body Sensation**	**Yes ☐ No ☐**
Burning	**Yes ☐ No ☐**	**Glare/ Light sensitivity**	**Yes ☐ No ☐**
Eye/ Lid Infection	**Yes ☐ No ☐**	**Itching**	**Yes ☐ No ☐**
Distorted Vision/ Halos	**Yes ☐ No ☐**	**Loss of Side Vision**	**Yes ☐ No ☐**
Double Vision	**Yes ☐ No ☐**	**Loss of Vision**	**Yes ☐ No ☐**
Dryness	**Yes ☐ No ☐**	**Mucous Discharge**	**Yes ☐ No ☐**
Excess Tearing/ Watering	**Yes ☐ No ☐**	**Redness**	**Yes ☐ No ☐**
Eye Pain/ Soreness	**Yes ☐ No ☐**	**Sandy/ Gritty Feeling**	**Yes ☐ No ☐**
Flashes/ Floaters in Vision	**Yes ☐ No ☐**	**Tired Eyes**	**Yes ☐ No ☐**

If you answered *Yes* to any of the above or have a condition not listed, please explain:_____
_____

2) OCULAR CONDITIONS

Glaucoma	**Yes ☐ No ☐**	**Blindness**	**Yes ☐ No ☐**
Cataracts	**Yes ☐ No ☐**	**Crossed Eyes/Strabismus**	**Yes ☐ No ☐**
Macular Degeneration	**Yes ☐ No ☐**	**Lazy Eye/Amblyopia**	**Yes ☐ No ☐**
Eye Injury	**Yes ☐ No ☐**	**Diabetic Retinopathy**	**Yes ☐ No ☐**
Retinal Disease/Condition	**Yes ☐ No ☐**	**Dry Eyes**	**Yes ☐ No ☐**
Other Ocular Condition	**Yes ☐ No ☐**	**Refractive Surgery**	**Yes ☐ No ☐**

3) MEDICAL HISTORY

Do you have any allergies or allergies to medication?_____
_____
List ANY medications you take prescription or over the counter:_____
_____
List ALL current health conditions:_____
_____
List ALL major injuries, surgeries and hospitalization:_____
_____

Are you pregnant or nursing? **Yes ☐ No ☐**
Do you wear glasses? **Yes ☐ No ☐** **How old is your present pair?**_____
Do you wear contact lenses? **Yes ☐ No ☐** **How old is your current pair?**_____
What type of contact lenses? **Hard ☐ Soft ☐** **Do you sleep in them?** **Yes ☐ No ☐**
Are they comfortable? **Yes ☐ No ☐** **How often do you change/dispose of your CL?** _____
Interested in refractive surgery? **Yes ☐ No ☐**

4) FAMILY HISTORY

Disease/ Condition:		**If yes, please indicate which relative; specify maternal or paternal if necessary**
Glaucoma	**Yes ☐ No ☐**	_____
Cataracts	**Yes ☐ No ☐**	_____
Macular Degeneration	**Yes ☐ No ☐**	_____

Eye Injury Yes ☐ No ☐ _____
Retinal Detachment/Disease Yes ☐ No ☐ _____
Other Diseases Yes ☐ No ☐ _____
Blindness Yes ☐ No ☐ _____
Crossed Eye/Lazy Eye Yes ☐ No ☐ _____
Diabetes Yes ☐ No ☐ _____
Cancer Yes ☐ No ☐ _____
Heart Disease Yes ☐ No ☐ _____
High Blood Pressure Yes ☐ No ☐ _____
Kidney Disease Yes ☐ No ☐ _____
Lupus Yes ☐ No ☐ _____
Thyroid Disease Yes ☐ No ☐ _____

5) SOCIAL HISTORY

Do you drive? Yes ☐ No ☐
Any visual difficulties? Yes ☐ No ☐
If *yes* please explain_____
Do you use tobacco/e-cigarette? Yes ☐ No ☐ **If *yes*, what type/ amount/ how long?** _____
Do you use illegal drugs Yes ☐ No ☐ **If *yes*, what type/ amount/ how long?** _____
Do you drink alcohol? Yes ☐ No ☐ **If *yes*, how often?**_____
Have you ever been exposed to or infected with any sexual transmitted diseases/ HIV? Yes ☐ No ☐

6) REVIEW OF SYMPTOMS

Do you currently have or have ever had any of the following:

CONSTITUTIONAL
- **Fever** Yes ☐ No ☐
- **Weight Loss** Yes ☐ No ☐
- **Weight Gain** Yes ☐ No ☐

CARDIOVASCULAR/VASCULAR
- **Heart Condition** Yes ☐ No ☐
- **High Blood Pressure** Yes ☐ No ☐
- **Vascular Disease** Yes ☐ No ☐

EAR, NOSE, MOUTH, THROAT
- **Allergies/ Hay Fever** Yes ☐ No ☐
- **Chronic Cough** Yes ☐ No ☐
- **Dry Mouth** Yes ☐ No ☐
- **Ear Infection** Yes ☐ No ☐
- **Sinus Congestion** Yes ☐ No ☐

RESPIRATORY
- **Asthma** Yes ☐ No ☐
- **Bronchitis** Yes ☐ No ☐
- **Emphysema** Yes ☐ No ☐

GASTROINTESTIONAL
- **Constipation** Yes ☐ No ☐
- **Diarrhea** Yes ☐ No ☐

GENITOURINARY
- **Bladder** Yes ☐ No ☐
- **Kidney** Yes ☐ No ☐

MUSCULOSKELETAL
- **Arthritis/Rheumatoid** Yes ☐ No ☐
- **Osteoarthritis** Yes ☐ No ☐
- **Muscle/Joint Pain** Yes ☐ No ☐

INTEGUMENTARY (Skin)
- **PXE (Pseudoxanthoma Elasticum)** Yes ☐ No ☐

NEUROLOGICAL
- **Headache** Yes ☐ No ☐
- **Migraine** Yes ☐ No ☐
- **Seizures** Yes ☐ No ☐

PSYCHIATRIC Yes ☐ No ☐

ENDOCRINE
- **Diabetes** Yes ☐ No ☐
- **If *yes*, your most recent blood sugar level?** _____
- **Thyroid/ Other Glands** Yes ☐ No ☐

HEMATOLOGIC/LYMPHATIC
- **Anemia** Yes ☐ No ☐
- **Bleeding Problems** Yes ☐ No ☐

IMMUNOLOGY
- **Syphilis** Yes ☐ No ☐
- **Hepatitis** Yes ☐ No ☐

ALLERGIES Yes ☐ No ☐

☐ **Doctor recommends annual dilated fundus exam (DFE), photos and visual field testings (VF) to rule out and/or detect cataract, glaucoma, macular degeneration, retinal diseases/other possible causes that can affect your vision. These services may not be covered/ partially covered by your insurance plan.)**
☐ **Consent for DFE & VF** ☐ **Reschedule to a later date** ☐ **DFE only** ☐ **VF only** ☐ **Photos only** ☐ **Medical Eye Exam**

Patient/Guardian Signature:_____ **Date:** _____/_____/_____