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

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 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 Elasti) 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 ☐

☐ **Medical Eye Exam to detect/rule out ocular and retinal diseases is recommended on annual basis through dilated fundus exam (DFE), photos, visual field testings (VF) or OCT scan. These elective services might not be covered/partially covered by your medical insurance.**

☐ **Reschedule to a later date** **Consent for** ☐ **DFE** ☐ **VF** ☐ **Photos** ☐ **OCT Scan** ☐ **Medical Eye Exam**

Patient/Guardian Signature:______________________________ **Date:** ______/______/______

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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 accessories.

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. $40 Co-pay applies if patient chooses to used own 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 $50.00 no show fee. Patient is responsible to CALL the office to reschedule or cancel any appointment at least 24 hours in advance.

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.

There will be a $15 fee for medical record per request.

H2T utilizes electronic communications either through email or text messaging. Patient has the option to opt-out of these communication at anytime by following the instructions on the electronic communications received.

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

I, ____, have read, understand and acknowledge the policies stated above.

Signature________________________________ Date: _______________________