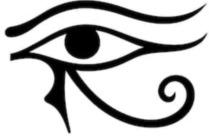

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Christopher L. Kelly, M.D.
Stephen J. Kelly, M.D.
Sara M. Mullins, M.D.

Welcome to our practice! Thank you for choosing us for all of your eye care needs. We provide services that range from contact lens fittings to advanced cataract surgery. Annual eye exams are just as important as your annual physicals with your primary care physician. These allow us to detect significant eye disease, such as diabetic retinopathy, glaucoma, and macular degeneration before they cause any permanent vision loss or damage.

Your first visit to our office typically ranges from 1-2 hours. We will dilate your eyes for your examination. Following dilation, you may have difficulty reading and may want to consider this when planning your schedule and appointment. While it is safe for you to drive, you may prefer to have a driver secondary to light sensitivity and glare. **Due to COVID-19 our waiting room is closed. You do not need to call to let us know you have arrived. Wait in your call until your exact appointment time then check in at the front desk.**

Prior to your appointment, please have the following available (and **bring with you to your appointment**):

- Completed patient information and history form (front and back) **PLEASE DO NOT MAIL BACK TO US.**
    - Medication list
    - Current glasses
    - Current contact lens prescription
- Your insurance card
- Driver's license or picture ID

If your insurance requires a referral, you are responsible for contacting your primary care doctor before your appointment. We suggest you do this as soon as possible. Your co-payment is due at the time of your visit. We accept cash, check and all major credit cards. If you have not met your annual deductible, you may be responsible for all or part of that amount as well. If you do not have health insurance, please call our office to discuss your payment options.

As part of your exam, we may find it necessary to perform a refraction. This is the portion of the exam in which we determine your appropriate eyeglass prescription. Many insurance companies do not cover this service. If your insurance company does not cover this testing, you are responsible for the $35 refraction fee. If you would like us to fit you for contact lenses, you are all responsible for the contact lens fitting fee.

Due to social distancing protocols, we are asking patients only and no visitors in the office. If you have extenuating circumstances, please notify our staff so we may try to accommodate your needs.

For the safety of our staff and patients please wear your mask throughout your entire visit. Given our responsibility to ensure everyone's safety we will not see you without a mask.

We look forward to seeing you soon! If you have any questions regarding your upcoming appointment, please do not hesitate to contact us at 205-933-2250.

Sincerely,

The physicians and staff of Dr. Kelly and Associates

PLEASE PRINT

PATIENT'S NAME: ____
LAST, FIRST MIDDLE

BIRTHDATE: ______________________ SEX: ☐ M ☐ F

SELECT ONE: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

SOCIAL SECURITY #: ______________________

ADDRESS: ____

____
CITY, STATE ZIPCODE

HOME PH: ______________ CELL PH: ______________ WORK PH: ______________

PREFERRED PHONE (SELECT ONE): ☐ HOME ☐ CELL ☐ WORK

EMAIL: ____

OCCUPATION: ____

PHARMACY: ______________________________ PHARMACY PH: ______________

SPOUSE'S NAME: ______________________________ SPOUSE DOB: ______________

IF MINOR: PARENT'S NAME: ______________________________ DOB: ______________

EMERGENCY CONTACT NAME: ______________________________ PH: ______________

RELATIONSHIP TO PATIENT: ______________________________ ALT PH: ______________

PRIMARY CARE DOCTOR: ______________________________ PH: ______________

KNOWN MEDICAL PROBLEMS: ____

DRUG ALLERGIES: ____

REFERRED BY: ____

NAME(S) OF PERSONS WE MAY SPEAK TO ABOUT YOUR MEDICAL CARE:

NAME: ______________________________ RELATIONSHIP: ______________

NAME: ______________________________ RELATIONSHIP: ______________

____

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PARTY

MEDICAL HISTORY QUESTIONNAIRE

Name: ____ Date _______________

Date of birth _________________ Date of last eye exam _________________

List any **medications** you currently take (prescription and over-the-counter):

____

____

Do you have **allergies** to any medications? ☐ YES ☐ NO

If YES, list the medications:

____

List all **major illness** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injures** (concussion, etc.): ____

____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy, etc.):

____

____

Do you ***currently*** have any problems in the following areas? If YES, please provide information.

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

	YES	NO	Explanation of Problem
GENERAL/CONSTITUTIONAL			
Fever			
Weight Loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Sto etc.) (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

	YES	NO	Relationship to Patient
DISEASE			
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Education (high school, vocational school, college degree): ______________________

Do you live in a nursing home? ☐ YES ☐ NO

If YES, Name of nursing home: ______________________

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Have you ever tried to wear contact lenses? ☐ YES ☐ NO

Do you currently wear glasses? ☐ YES ☐ NO

If YES, how long have you had the current prescription? ______________________

Do you drink Alcohol? ☐ YES ☐ NO If YES: ☐ occasional ☐ 1 per day ☐ 2-3/day ☐ 4+/day

Do you smoke? ☐ YES ☐ NO If YES: ☐ occasional ☐ ½ pack/day ☐ 1 pack/day ☐ 1+pack

Have you ever had a blood transfusion? ☐ YES ☐ NO

History Reviewed. ☐ No Changes ☐ Additions as noted above

Physician's Signature: ______________________ Date: ______________