

PATIENT HISTORY RECORD

▲ DATE (MM/DD/YY)	▲ REFERRED BY	▲ BIRTH DATE
▲ PATIENT'S NAME		▲ SEX ▲ AGE
▲ ADDRESS		▲ PHONE (H)
▲ EMPLOYER	▲ OCCUPATION	▲ PHONE (W)
▲ SOC. SEC. NO.		▲ PRIMARY CARE PHYSICIAN

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)
 Yes No If YES, please explain: _____
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
 Yes No If YES, please explain: _____
3. Have you ever had any surgery:
 Yes No If YES, please provide date and reason _____
4. Have you ever been hospitalized
 Yes No If YES, please provide date and reason _____
5. Do you take any medications?
 Yes No If YES, please list: _____
 Do you take any eye medications?
 Yes No If YES, please list: _____
6. Do you have any drug or food allergies?
 Yes No If YES, please list: _____

Review of Systems

- | | Yes | No | If YES, please explain: |
|--|--------------------------|--------------------------|-------------------------|
| 1) Do you currently have any of the follow problems: | | | |
| Chronic fever, unexpected weight loss/gain, fatigue | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart problems (e.g. chest pain, irregular heart beat) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Respiratory problems (e.g., shortness of breath, wheezing, coughing) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting).... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Urinary problems (e.g. pain or discomfort, blood in urine) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Skin problems (e.g. rashes, excessive dryness) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Neurologic problems (e.g., numbness, weakness, headaches, paralysis)..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Psychiatric problems (e.g., depression, anxiety) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7. Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
Yes <input type="checkbox"/> No <input type="checkbox"/> If YES, please explain: _____ | | | _____ |

8. Do you smoke? If yes, how much? drink alcohol? If yes, how much
- If employed, how many hours per week do you work?
- Does your employment contribute to any stress in your life Yes No

▲ Comments

▲ M.D. Signature **▲ Date**

Account # _____

PATIENT INTRODUCTION

Referred by:						
Mr. Mrs. Miss	Last Name	First Name	Middle			
Street Address	Apt. No.	City	State	Zip	Home Phone	
Social Security #	Date of Birth	Male () Female ()		Single () Married ()		
Employed by:		Employer's Address				
Occupation		Business Phone				
<i>Spouse/Parent Name</i>		Date of Birth	Social Security #			
Employed by:		Employer's Address			Business Phone #	
Nearest Friend or Relative		Relationship		Phone (work) (home)		

Will this claim be covered under Worker's Compensation ()Yes ()No

If yes: Name of Company	Address of Company
Phone #	Treatment Authorized by:

Please complete the section below if someone other than the patient is responsible for the payment of services.

Last Name	First Name	Middle
Street Address	Apt. No.	City
	State	Zip
Home Phone		
Employed by:	Employer's Address	Occupation
Business Phone	Relationship to Patient	

I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, **I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED.**

Today's Date	Signature of Patient, or Parent, or Responsible Party
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