

# Eyecare Associates

## Patient Medical History

Revised 4/12/2010

Last Name: _____	First Name: _____	MI: _____	Birth Date: ___ / ___ / ___
Patients Medical Doctor: _____	Occupation: _____	SS # _____	Male    Female

**MEDICAL HISTORY**

Do you have any allergies to medications?    No / Yes    If yes explain.

List all major injuries, surgeries and/or hospitalizations you have had in the past 5 years:

Circle any of the following that you have had: Crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury.

Are you pregnant and/or nursing?    No / Yes  
 Do you wear glasses?    No / Yes    If yes, how old is your present pair of lenses?  
 Do you wear contact lenses?    No / Yes    If yes, how old is your present pair of lenses?  
 Type of contact lenses:    Rigid            Soft            Extended wear            Other            Are they comfortable? No / Yes

**FAMILY HISTORY** *Have your parents, grandparents, siblings been treated for the following conditions:*

Disease/Condition	N	Y	Relationship to you:	Disease/Condition	N	Y	Relationship to you:
Arthritis				Cancer			
Diabetes				High Blood Pressure			
Glaucoma				Heart Disease			
Macular Degeneration				Kidney Disease			
Any Other							

**SOCIAL HISTORY** *This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.*

Yes, I would prefer to discuss my social history information directly with my doctor. (check circle)

Do you drive?    No / Yes    If yes, do you have visual difficulty when driving?    No / Yes  
 If YES to visual difficulty please describe:  
 Do you use tobacco products?    No / Yes    If yes, type / amount / how long:  
 Do you drink alcohol?    No / Yes    If yes, type / amount / how long:  
 Do you use illegal drugs?    No / Yes    If yes, type / amount / how long:  
 Have you ever been exposed to or infected with:     Gonorrhea     Hepatitis     HIV     Syphilis     N/A

**REVIEW OF SYSTEMS** *Do you currently, or have you ever had any problems in the following areas:*

	N	Y	Provide explanation / medications
Eyes (glaucoma, cataract, retinal disease, etc.)			
Skin (acne, warts, skin cancer, rosacea, etc.)			
Cardiovascular (heart disease, chest pain, irregular heart beat, etc.)			
Endocrine (diabetes, thyroid)			
Gastrointestinal (stomach ulcers, intestinal disease, etc.)			
Musculoskeletal (arthritis, muscle aches, joint pain, swollen joints)			
Neurological (stroke, numbness, weakness, headaches, etc.)			
Respiratory (asthma, emphysema, etc.)			
Ear / Nose / Mouth / Throat (sinus, ear infection, chronic cough, etc.)			
Allergic / Immunologic (hay fever, lupus, HIV, hepatitis)			
Blood / Lymph (cholesterolemia, anemia, etc.)			
Psychiatric (anxiety, depression, insomnia)			

<b>For Office Use Only</b>	<b>Follow-up visits, reviewed and signed:</b>
Doctor's Signature: _____	Doctor's Signature: _____ Date: _____
Date: _____	Doctor's Signature: _____ Date: _____
	Doctor's Signature: _____ Date: _____

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## Patient Medical History

(Please Print Clearly)

Revised 4/12/2010

Today's date:							
PATIENT INFORMATION							
Patient's Last Name:	First Name:	Middle:	Sex:	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	Social Security #	
					/ /	- -	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):				
Street address:			Home phone no.:		Alternate phone no.:		
			( )		( )		
P.O. Box:		City:		State:		ZIP Code:	

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)						
Person responsible for bill:	Birth date:	Address (if different from above):			Home phone no.:	
	/ /				( )	
Is this person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Employer:	Is this patient covered by insurance?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Name of Primary Insurance</b>		Group #:		Policy #:		
Subscriber's name:		Soc. Sec. #:		Birth date:		
		- -		/ /		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
<b>Name of secondary Insurance</b>		Group #:		Policy #:		
Subscriber's name:						
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
<b>Name of Vision Insurance</b>		Group #:		Policy #:		

AUTHORIZATION / FINANCIAL AGREEMENT/ HIPPA	
<p><input type="checkbox"/> I hereby authorize my examinations, including <b>dilation</b> where drops are used to enlarge the pupils in order to get a better view of the inside of my eye. Dilating drops can blur vision for an unspecified length of time and varies from person to person. Some people may require a driver after being dilated.</p> <p><input type="checkbox"/> I authorize payment directly to Eyecare Associates for all benefits payable to me under the terms of the insurance policy for treatment of services provided to me or my dependents. I authorize the release of any medical information necessary to process such insurance claims.</p> <p><input type="checkbox"/> I understand that I am financially responsible for all charges whether or not they are covered by insurance. All prices are an estimate of what the final bill could be.</p> <p><input type="checkbox"/> I am aware of Eyecare Associates 'Notice of Privacy Practices' (HIPPA). Copy available upon request.</p>	
<hr style="width: 80%; margin: 0 auto;"/> <i>Patient/Guardian signature</i>	<hr style="width: 80%; margin: 0 auto;"/> <i>Date</i>