Patient History Form

Name:_____

Date of birth: _____ Date:_____

Tell us about your medical history
Have you had or do you have:

yes	no	
		AIDS or HIV
		allergies (seasonal)
		Alzheimer's disease
		anxiety
		arthritis/Rheumatoid
		asthma
		back problems
		bleeding or clotting disease
		cancer
		carpal tunnel syndrome
		cholesterol
		chronic headaches/ migraines
		COPD (lung disease)
		Crohn's disease
		dementia
		depression
		diabetes
		fibromyalgia
		hearing impairment (hearing aid)
		heart attack
		heart problems
		Hepatitis
		hypertension (high blood pressure)
		kidney disease
		lupus
		Multiple Sclerosis
		neuropathy
		osteoporosis
		Parkinson's disease
		prostate problems
		seizures
		Sjogren's syndrome
		stroke
		thyroid disorder
	Other:_____	

_____

_____

_____

Tell us about your eye history
Have you had or do you have:

yes	no	
		allergies (seasonal)
		amblyopia/lazy eye
		blepharitis
		cataracts
		cataract surgery
		chalazion/stye
		contact lens wearer
		corneal dystrophy
		corneal transplant
		corneal ulcer
		diabetic retinopathy
		dry eye
		floaters
		glaucoma suspect
		glaucoma
		keratoconus
		laser treatment
		LASIK/PRK/refractive surgery
		lid surgery
		macular degeneration
		nevus
		ocular tumor
		optic neuritis
		optic neuropathy
		posterior vitreous detachment (PVD)
		pterygium
		retinal detachment
		retinal hole
		retinal surgery
		strabismus/crossed/turned eye
		trauma
	Other:_____	

_____

_____

_____

Primary Doctor: _____

Signature: _____

PLEASE TURN OVER AND FILL OUT THE BACK

Name: _____ Date: _____

Do you have a surgical history of:

yes	no	
		amputation
		angioplasty
		back surgery
		bladder surgery
		blood transfusion
		bowel resection
		chemotherapy/radiation
		dialysis
		gallbladder surgery
		heart surgery
		hernia
		joint replacement
		kidney surgery
		organ transplant
		pacemaker/defibrillator
		prostate surgery
		stent
		thyroid surgery
	Other:	

_____

_____

_____

Not including you, is there a family history (mother, father, grandparents, siblings) of:

yes	no	
		I know my family history

If yes, then ***who*** has a history of:

		cancer
		cataracts
		crossing/lazy eye
		diabetes
		glaucoma
		heart disease
		high blood pressure
		macular degeneration
		migraine headaches
		retinal detachment
		stroke
	Other:_____	

_____

Please tell us about yourself:

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widow

yes	no		
		Do you drive?	Height:
		Do you live alone?	Weight:

Circle one: Never smoked Former smoker Smoker

Does anyone smoke inside your home? Yes No

Cigarettes per day _____

How many years?_____

List current eye drops or ointments: ☐ None

_____

List your current medications: ☐ None

_____

_____

List any allergies to medications: ☐ None

_____

Name and location of your pharmacy: _____

Signature: _____ Doctor Signature: _____

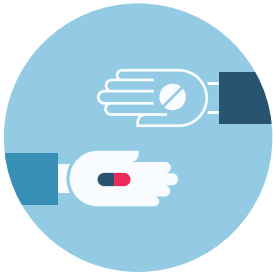
Insurance Reminders

Don't Forget!

Bring your insurance card every time you come in!

Understand your insurance coverage.

- What is your co-pay?
- What is your deductible?
- What visits are covered?



Understand your pharmacy benefits.

- Do you need 30-day or 90-day prescriptions
- Should you have generic or brand names?
- What pharmacies do you use?

Understand your referral requirements.

- Do you need referrals to see specialists?
- Do you need referrals for emergency care?
- Which doctors and hospitals can you use?

Questions, problems and concerns about your insurance?

Contact your employer's human resource office or your insurance plan's costumer relations department.

Remember—Not all insurance plans are the same. Lower cost plans usually have higher deductibles and co-pays. Your doctor's office **does not** have information about your personal insurance coverage. We can only verify your benefits if we have your insurance contract number, subscriber name and date of birth.