Welcome To Our Office

Medical History Record

Name: _____ Birth Date: ____/____/____ Age: ____
First MI Last

Mailing Address: _____City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell: (____) _____ Sex: ____ Marital Status: ___

Social Security No._____ E-mail:_____

Race (Check One):
☐ Caucasian/ White ☐ Black or African American
☐ American Indian or Alaskan Native ☐ Native Hawaiian/ Other Pacific Islander
☐ Asian ☐ Hispanic/ Latino

Employer: _____ Occupation: _____

Work Phone: _____

Notify In Case Of Emergency: _____Phone: _____

Relationship: _____

Family Doctor: _____ Phone: _____

Date of last physical: _____ Height: _____ Weight: _____

Referring Doctor: _____ Phone: _____

List all medications & dosage you take: (Prescription and Over-the-Counter) Attach list if necessary.

	Medication name	Dosage	Reason for taking
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____

Pharmacy: _____

Do you have allergies to any medications? Yes ☐ NO ☐ If YES, List medications and **reactions**:

_____

_____ _____

Past History

List any significant illnesses, surgeries, and injuries you have had in the past:

_____

_____

List any significant eye history (i.e.: cataracts, macular degeneration, glaucoma, injuries to eyes) you have had:

_____

_____

Family History (M=mother, F= Father, B=brother, S= sister, GP=grandparent)

Patient	Family	If Family, what relation to you	Patient	Family	If Family, what relation to you
□	□	Glaucoma_____	□	□	Hepatitis_____
□	□	Lazy Eye_____	□	□	HIV+/AIDS_____
□	□	Diabetes_____	□	□	Neurofiromatosis_____
□	□	High Blood Pressure_____	□	□	Keratoconus_____
□	□	Heart Disease_____	□	□	Lyme Disease_____
□	□	Sarcoidosis_____	□	□	Graves/Thyroid Disease_____
□	□	Asthma/Breathing Problems_____	□	□	Myasthenia Gravis _____
□	□	Migraine Headaches_____	□	□	Retinal Detachment_____
□	□	Lupus _____	□	□	Multiple Sclerosis_____
□	□	Cataracts_____	□	□	Blindness_____
□	□	Cataract Surgery_____	□	□	Retinitis Pigmentosa _____
□	□	Corneal Dystrophies_____			
□	□	Macular Degeneration			

Social History

Do you currently wear glasses? □ Yes □ No
How long have you had the current pair? _____
Do you currently wear contacts? □ Yes □ No How old are they? _____
Have you ever tried to wear contacts? □ Yes □ No
Do you drive? □ Yes □ No
Do you smoke? □ Yes □ No If YES, How many packs a day? _____
Did you quit? □ Yes □ No How long ago? _____
Do you drink alcohol? □ Yes □ No If YES, How many drinks a day/ week? _____
Do you use illegal drugs? □Yes □No
Have you ever had a blood transfusion? □ Yes □ No
Have you ever had a sexually transmitted disease? □ Yes □ No

Responsible Party's Information (If minor)

Name: _____ Relationship to patient: _____
Street Address: _____ City: _____ State: ____ Zip: _____
Employer: _____ Work Phone: _____
Date of birth: _____ Social Security No: _____

Primary Insurance Information (Please provide us with your card and driver's license)

Name of Insurance _____ Name of Cardholder _____

ID# _____ Group# _____ Cardholder's date of birth _____

Cardholder's Social Security No _____ Cardholder's Employer _____

Secondary Insurance Information

Name of Insurance _____ Name of Cardholder _____

ID#_____ Group#_____ Cardholder's Date of birth:_____

Cardholder"s SS#_____ Cardholder's Employer: _____

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RELEASE OF INFORMATION:

I hereby authorize Gibson County Eyecare to disclose or obtain all or any part of my or my dependent's records to or from any person or corporation which may be liable for all or part of the charges of Gibson County Eyecare, including but not limited to insurance companies, employers or employees of Gibson County Eyecare until hereby revoked by the patient or guardian.

ASSIGNMENT OF BENEFITS:

I hereby assign all medical benefits covered by my insurance to Gibson County Eyecaref for her services rendered, until revoked by the patient or guardian. I understand that I am financially responsible for all charges incurred and not covered by insurance.

Acknowledgement of Notice of Privacy Practices (HIPPA):

I acknowledge that I have been given or offered a copy of Gibson County Eyecare Notice of Privacy Practices. This Notice discloses my protected health information, certain restrictions on the use and disclosure of my healthcare information, and the rights I may have regarding my protected health information.

X _____

Signature of Patient (or Personal Representative) Date Relationship to Patient

Review of Systems

Do you presently have any problems in the following areas?

Allergies/Immunologic	**Yes**	**No**
Seasonal Allergies	□	□
Immune Problems	□	□
General Allergies	□	□
Other_____		

Cardiovascular	**Yes**	**No**
Congestive Heart Failure	□	□
Heart Murmur	□	□
Heart Attacks	□	□
Heart Palpitations	□	□
Blood Pressure	□	□
Chest Pain/Angina	□	□
Other_____		

Constitutional	**Yes**	**No**
Fever	□	□
Weight loss	□	□
Fainting	□	□
Dizziness	□	□
Other_____		

Endocrine	**Yes**	**No**
Diabetes	□	□
Type I		
Type II		
How long?_____		
Today's reading_____		
Pancreatic Cancer	□	□
Crohn's Disease	□	□
Thyroid Disorder	□	□
Hormone Replacement	□	□
Elevated Cholesterol	□	□
Hyperthyroidism	□	□
Other_____		

Gastrointestinal	**Yes**	**No**
Jaundice/Hepatitis	□	□
Ulcers/Bleeding	□	□
Hiatus Hernia	□	□
IBS	□	□
Acid Reflux	☐	☐
Other_____		

Genitourinary	**Yes**	**No**
Kidney Disease	□	□
Kidney Stones	□	□
Other_____		

Head (Ears,Nose,Mouth)	**Yes**	**No**
Hearing problems	□	□
Sinus Congestions	□	□
Headaches	□	□
Chronic Cough	□	□
Dry Throat/Mouth	□	□
Other_____		

Hematologic/ Lymphatic	**Yes**	**No**
Anemia	□	□
Sickle Cell Disease	□	□
Leukemia	□	□
Other_____		

Cancer Type

_____

Integumentary	**Yes**	**No**
Psoriasis	□	□
Acne Rosacea	□	□
Lupus	□	□
Other_____		

Musculoskeletal	**Yes**	**No**
Arthritis	□	□
Rheumatoid Arthritis	□	□
Muscle/Joint Pain	□	□
Fibromyalgia	□	□
Scoliosis	□	□
Osteoporosis	□	□
Other_____		

Neurological	**Yes**	**No**
Migraines	□	□
Seizures	□	□
Stoke/Paralysis	□	□
Vertigo	□	□
Bell's Palsy	□	□
Epilepsy	□	□
Multiple sclerosis	□	□
Muscular Dystrophy	□	□
Neurofibromatosis	□	□
Other_____		

Psychiatric	**Yes**	**No**
Depression	□	□
Schizophrenia	□	□
Bipolar	□	□
ADD	□	□
Alzheimer's	□	□
Anxiety Disorder	□	□
Autism	□	□
Dementia	□	□

Respiratory	**Yes**	**No**
Asthma	□	□
Emphysema	□	□
Tuberculosis	□	□
Lung Cancer	□	□
Sarcoidosis	□	□
COPD	□	□
Cystic Fibrosis	□	□
Other_____		