

Patient Last Name _____ First Name _____ MI _____

Address _____

City/State/Zip _____

Name of Referring Physician _____

M ____ F ____ AGE _____ Date of Birth _____ Social Security # _____

Home Phone # _____ Cell # _____ Work Phone # _____

Phone # you prefer to be reached 1) _____ 2) _____

Employer _____ Occupation _____

Employer's Address: _____

Spouse's Name: _____ Spouse's Cell # _____

Spouse's Employer & Phone: _____

Name & Number of person not living at home in case of an emergency _____

Insurance Information

Insurance Name _____

Group # _____ ID/Policy # _____

AUTHORIZATION AND RELEASE

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination provided during the period of such care to my insurance company and/or health practitioners.

I authorize payment of benefits to the physician for services provided. I understand that my insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents and all collection, attorney and court fees that are added to any unpaid balance. I permit a copy of this authorization to be used in place of the original.

Parent/Patient
Signature _____ Date _____

Medical History Questionnaire

Name: _____ Birth Date: _____ Sex: M F

Review of Systems. Please check either "Yes" or "No" for each of the following questions.

<p><u>Eyes</u></p> <p>Loss of vision? Yes No</p> <p>Blurred vision? Yes No</p> <p>Loss of side vision? Yes No</p> <p>Double vision? Yes No</p> <p>Dryness? Yes No</p> <p>Redness? Yes No</p> <p>Itching? Yes No</p> <p>Excessive tearing/watering? Yes No</p> <p>Glare/light sensitivity? Yes No</p> <p>Strabismus (crossed eyes)? Yes No</p> <p>Amblyopia (lazy eye)? Yes No</p> <p>Glaucoma? Yes No</p> <p>Retinal detachment? Yes No</p> <p>Macular degeneration? Yes No</p> <p><u>Neurological</u></p> <p>Headaches/migraines? Yes No</p> <p>Cerebral Palsy? Yes No</p> <p>Seizures? Yes No</p> <p>Stroke? Yes No</p> <p>Hydrocephalus? Yes No</p> <p><u>Gastrointestinal</u></p> <p>Reflux? Yes No</p> <p>Ulcers? Yes No</p> <p><u>Cardiovascular</u></p> <p>High blood pressure? Yes No</p> <p>Heart condition? Yes No</p>	<p><u>Respiratory</u></p> <p>Asthma? Yes No</p> <p>Emphysema? Yes No</p> <p><u>Psychiatric</u></p> <p>Anxiety? Yes No</p> <p>Depression? Yes No</p> <p><u>Endocrine</u></p> <p>Diabetes (NIDDM/IDDM)? Yes No</p> <p>Thyroid (Hyper/Hypo)? Yes No</p> <p><u>Musculoskeletal</u></p> <p>Osteoarthritis? Yes No</p> <p>Rheumatoid arthritis? Yes No</p> <p><u>Genitourinary</u></p> <p>Kidney stones? Yes No</p> <p><u>Dermatological</u></p> <p>Eczema? Yes No</p> <p>Rosacea? Yes No</p> <p><u>Hematologic/Lymphatic</u></p> <p>Anemia? Yes No</p> <p>Bleeding disorders? Yes No</p> <p><u>Allergic/Immunologic</u></p> <p>Seasonal allergies? Yes No</p> <p>Sinus problems? Yes No</p>	<p><u>Social History</u></p> <p>Patient lives with: _____</p> <p>Occupation/ Hobbies/Child's interests: _____</p> <p><u>Is patient allergic to:</u></p> <p>Medications? Yes No</p> <p>List: _____</p> <p>Foods? Yes No</p> <p>List: _____</p> <p>Latex? Yes No</p> <p>History of anesthesia problems? Yes No</p> <p><u>Family History</u> <i>(Patient's parents, grandparents, & siblings only)</i></p> <p>Strabismus (crossed eyes)? Yes No</p> <p>Amblyopia (lazy eye)? Yes No</p> <p>Blindness? Yes No</p> <p>Cancer? Yes No</p> <p>Diabetes? Yes No</p> <p>Glaucoma? Yes No</p> <p>Hypertension/heart disease? Yes No</p> <p>Retinal detachment? Yes No</p> <p>Thyroid disease? Yes No</p>
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Other patient conditions or complaints? _____

Patient's primary physician/pediatrician: _____

Please list all medications patient is currently taking: _____

Past history

Illnesses or injuries: _____

Surgeries: _____

For pediatric patients only:

Child's weight at birth: _____ Was pregnancy full-term? Yes No If no, how many weeks?

Complications or problems during pregnancy/delivery? _____

In Office Use Only

Physician's Signature: _____ Date: _____