

MEDICAL HISTORY RECORD

Home # _____

Name: _____ Cell # _____

Address: _____ Zip Code: _____

Birth Date: ____/____/____ E-mail: _____

Place of Employment: _____ Work # _____

Vision Insurance: _____ S.S.N./ID# _____

Medical Insurance: HMO/PPO _____ ID # _____

Personal Medical Information: Which of the following conditions do you experience? Please check all that apply

High Blood Pressure Neuropathy Depression
Diabetes Type ____ Seasonal Allergies Gastrointestinal Disease
Heart Disease Rheumatoid Arthritis Genitourinary Disease
Asthma Skin Conditions

Other Medical Conditions: _____

Date of your last routine eye examination: _____

Do you have allergic reactions to medications or other substances? Yes No

If yes, please list? _____

Name of Family/Primary Doctor _____ Date of last visit _____

Please check Yes or No

Do you smoke? Yes No how much? _____

Do you drink alcohol? Yes No how much? _____

Do you take medication? If yes, please list _____

Do you have family history of any of the following? If Yes, please check all that apply

High blood pressure Macular degeneration Cataracts
Diabetes Retinal detachment Glaucoma

Please explain any boxes you have checked _____

Do have any of the following? If Yes, please check all that apply

Dry Eyes Eye Surgeries Wear Glasses

Eye Injuries Blurred Vision Wear Contacts

Whom may we thank for referring you? _____

I hereby assign all medical benefits, to include all major medical benefits to which I am entitled, including Medicare, Medical, private insurance, and any other health plans to Dr. Victor Bautista and Dr. Katherine Stout, Eyes on Twenty-Fourth Optometry. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. I agree that I am responsible for my bill regardless of whether my insurance pays or denies my claim.

Patient's Signature: _____ Date: _____ Doctor's initials _____

Relationship to patient (if signed by a personal representative of patient): _____