The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

CURRENT MEDICATIONS (Rx or Over the Counter)
(We will be happy to copy your list)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies- non medicine	❑	❑
Cardiovascular Disease	❑	❑
High Blood Pressure	❑	❑
Elevated Cholesterol	❑	❑
Constitutional		
Blackouts	❑	❑
Weight Gain/Loss	❑	❑
Endocrine		
Diabetes	❑	❑
Thyroid Disorder	❑	❑
Gastrointestinal	❑	❑
Genitourinary	❑	❑
Ears/Nose/Mouth/Throat	❑	❑
Hemotologic/Lymphatic		
Cancer	❑	❑
Immunological	❑	❑
Integumentary		
Lupus	❑	❑
Ocular Rosacea	❑	❑
Dermatitis	❑	❑
Basal Cell Nevus	❑	❑
Hemangioma	❑	❑
Musculoskeletal		
Arthritis	❑	❑
Rheumatoid Arthritis	❑	❑
Neurological		
Bells Palsy	❑	❑
Brain Tumor	❑	❑
Malingering	❑	❑
Nystagmus	❑	❑
Vertigo	❑	❑
Psychiatric		
ADD	❑	❑
Autism	❑	❑
Brain Trauma	❑	❑
Respiratory		
COPD	❑	❑

Patient Medical History

Name of Family Physician_____
City_____
Date of Last Physical Check-up_____

Pharmacy _____
City_____
Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
_____
_____ _____
_____ _____
_____ _____

Vital Statistics: Height:_____ Weight: _____

Family Medical/Eye History (Check all that apply)

Is there a Family Medical History of any of the following:
❑No ❑Yes

	Relationship to Patient (Please be specific) …example, Paternal Grandmother, Maternal Grandfather, (M)Uncle, (P) Aunt, Brother, Sister…
Diabetes	❑_____
High Blood Pressure	❑_____
Heart Disease	❑_____
Glaucoma	❑_____
Macular Degeneration	❑_____
Corneal Problems	❑_____
Lazy Eye	❑_____
Retinal Problems	❑_____
Cataracts	❑_____

Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, *not* with your insurance company. Therefore, all charges are ultimately <u>your</u> responsibility, regardless of your insurance status.
If you have health insurance with which we participate: 1. We will bill your insurance claim for you. 2. We expect any required copayment at the time of service.
If we do not participate with your insurance: Filing claims is your responsibility. Accounts 90 days past due are subject to collections proceedings, if you default payment, you will be responsible for ALL costs of collections, including but not limited to collection fees, attorney fees and court costs.
I have read and understand the above:

Date_____ Signature: _____

Release of Records
I authorize this clinic to furnish medical information regarding the treatment of my current injury/illness to any or all of the following: physicians involved in my treatment; Medicare; my insurance carrier(s); or my employer (for work related injuries).

Date: _____ Signature:_____

HIPAA PRIVACY PRACTICE NOTICE
I acknowledge receiving a copy of the HIPAA Privacy Practice Notice – Website

Date: _____ Signature:_____