**Medical History Record**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medical Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drs. Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Exam:\_\_\_/\_\_\_/\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: White African American Asian American Indian or Alaska Native Other

Ethnicity: Not Hispanic or Latino Hispanic or Latino

**Medical History**

List all medical conditions you have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or nursing? No\_\_\_ Yes\_\_\_

Do you have any allergies to medications? No\_\_ Yes\_\_ If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other allergies? No\_\_\_ Yes \_\_\_ If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you take (including dosages, over the counter medications and home remedies):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ocular History**

List any of the following that you have had: cataracts, glaucoma, retinal disease, crossed eyes, lazy eye, drooping eyelid, eye infections, eye injury or eye surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye meds:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last eye exam:\_\_\_/\_\_\_/\_\_\_ Last Eye Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses? No\_\_\_ Yes\_\_\_ If yes, how old is your current prescription?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contacts? No\_\_\_ Yes\_\_\_ If yes, how old is your last contact lens prescription? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of contact lenses: Rigid\_\_\_ Soft\_\_\_ Extended wear\_\_\_ Other\_\_\_ Are they comfortable? Yes\_\_\_ No\_\_\_

How many hours do you spend on a computer per day?\_\_\_\_\_\_\_\_ Any eyestrain or fatigue? No\_\_\_ Yes \_\_\_

Are you interested in (please check): Contact lenses\_\_\_ LASIK\_\_\_ Sports Glasses\_\_\_ Sunglasses\_\_\_\_

**Family Medical History**

Please note any family members (parents, grandparents, siblings, children: living & deceased) with the following:

**Disease No Yes Relationship**

MEDICARE/INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits to Drs. Leahy and Disalvo-Ost on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated on item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. I understand that I am financially responsible for all charges not covered by my insurance. I understand that I will be billed for all charges that my insurance does not pay.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Diabetes \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart disease \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High blood pressure \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid disease \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lupus \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Ocular History**

**Disease No Yes Relationship**

Glaucoma \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cataract \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Macular Degeneration \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Retinal Detachment \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crossed eyes \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blindness \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Smoking Status: Never smoker\_\_\_ Former smoker\_\_\_ Current some day smoker (not daily) \_\_\_

Light smoker (<10 cigs/day)\_\_\_ Heavy smoker (>10cigs/day)\_\_\_

Do you drink alcohol? \_\_\_No \_\_\_Yes If yes, please circle- Frequency: occasionally / socially /daily Do you use recreational drugs? \_\_\_No \_\_\_Yes -If yes, type& how long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been infected with: HIV Gonorrhea Chlamydia Syphilis Hepatitis

Do you drive? \_\_\_Yes \_\_\_No If yes, do you have any visual difficulties when driving? \_\_\_No \_\_\_Yes

**Review of Systems**

Do you *currently* have any problems in the following areas:

|  |  |  |
| --- | --- | --- |
| **System** | **No** | **Yes** |
| **Ear, Nose, Mouth, Throat**  Allergies/Hay fever  Sinus congestion  Runny nose  Post-nasal drip  Chronic cough  Dry throat/mouth | \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_ | \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_ |
| **Respiratory**  Asthma  Chronic Bronchitis  Emphysema | \_\_\_  \_\_\_  \_\_\_ | \_\_\_  \_\_\_  \_\_\_ |
| **Vascular/Cardiovascular**  Heart pain  High blood pressure  Vascular disease | \_\_\_  \_\_\_  \_\_\_ | \_\_\_  \_\_\_  \_\_\_ |
| **Gastrointestinal**  Diarrhea  Constipation | \_\_\_  \_\_\_ | \_\_\_  \_\_\_ |
| **Bones/joints/muscles**  Rheumatoid arthritis  Muscle pain  Joint pain | \_\_\_  \_\_\_  \_\_\_ | \_\_\_  \_\_\_  \_\_\_ |
| **Lymphatic/hematologic**  Anemia  Bleeding problems | \_\_\_  \_\_\_ | \_\_\_  \_\_\_ |
| **Allergic/Immunologic** | \_\_\_ | \_\_\_ |
| **Psychiatric/Behavioral** | \_\_\_ | \_\_\_ |

|  |  |  |
| --- | --- | --- |
| **System** | **No** | **Yes** |
| **Constitutional**  Fever, weight loss/gain | \_\_\_ | \_\_\_ |
| **Integumentary**  (Skin) | \_\_\_ | \_\_\_ |
| **Neurological**  Headaches  Migraines  Seizures | \_\_\_  \_\_\_  \_\_\_ | \_\_\_  \_\_\_  \_\_\_ |
| **Eyes**  Loss of Vision  Blurred Vision  Loss of side vision  Double vision  Dryness  Mucous Discharge  Redness  Sandy or gritty feeling  Itching  Burning  Foreign body sensation  Excess tearing  Glare/light sensitivity  Eye pain or soreness  Chronic infection  Stye or Chalazion  Flashes/floaters  Tired eyes | \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_ | \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_  \_\_\_ |
| **Endocrine**  Thyroid/other glands  Diabetes | \_\_\_  \_\_\_ | \_\_\_  \_\_\_ |

If you answered YES to any of the above or have a condition not listed, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list individuals we may speak to regarding your medical information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge there is a $30 fee for missed appointments or appointments canceled with less than 24 hour notice—Please Initial: \_\_\_\_\_\_