PATIENT MEDICAL HISTORY

Last Name:_____ First:_____ MI:_____

Address: _____ City: _____ State:_____ Zip_____

Day Phone: (____) _____ Cell (____) _____ Preferred: *cell* I *day* I *email*

Email: _____ Birth Date: ____/____/____ Soc. Sec. No.____-____-____

Occupation: _____ Employer: _____ *full-time I part-time*

Marital: ❑ S ❑ M ❑ D ❑ Other_____ Medical Doctor: _____

Guarantor: _____ Birth Date: ____/____/____ Soc. Sec. No.____-____-____

Relation to Insured ❑Spouse ❑Child ❑Other Employer: _____ *full-time I part-time*

Review of Systems

	No	Yes	
CARDIOVASCULAR	❑	❑	_____
Hypertension / Heart Disease / Stroke / Aneurysm			
CONSTITUTIONAL	❑	❑	_____
Dizziness / Weight loss/gain / Fever			
ENDOCRINE	❑	❑	_____
Diabetes (Type I or II) / Thyroid (Graves) / Cholesterol / Gout			
EYES	❑	❑	_____
Surgery / Loss of vision / Double vision / Flashes or Floaters			
GASTROINTESTINAL	❑	❑	_____
GERD / IBS / Ulcer / Gallbladder			
GENITOURINARY	❑	❑	_____
Prostate / Uterine / Kidney / Bladder			
HEAD	❑	❑	_____
Hearing Loss / Sore throat / Coughing / Vertigo			
BLOOD / LYMPHATIC	❑	❑	_____
Anemia / Blood Clots / Leukemia / Hodgkin's / Breast Cancer			
IMMUNE	❑	❑	_____
Infection / Herpes / Lyme / Sjorgren's / Autoimmune			
INTEGUMENTARY	❑	❑	_____
Acne / Rosacea /Lupus / Eczema / Dermatitis / Carcinoma			
MUSCULOSKELETAL	❑	❑	_____
Arthritis (RA) / Marfan's / MD /Muscle Pain			
NEUROLOGICAL	❑	❑	_____
Head Ache / Seizures / MS / MG / CP / Memory loss / TBI			
PSYCHIATRIC	❑	❑	_____
Depression / Anxiety / Bi-Polar / ADD / Autism			
RESPIRATORY	❑	❑	_____
Asthma / COPD / TB / Lung Disease			
ALLERGIES	❑	❑ *Rash / Itching / Anaphylaxis*	

Medication Allergies_____

Environmental Allergies_____

Ocular Allergies ❑ ❑ *Burning / Itching / Watering*

Family History

	No	Yes	*Relationship to Patient*
Blindness	❑	❑	_____
Glaucoma	❑	❑	_____
Macular	❑	❑	_____
Retinal Detach	❑	❑	_____
Crossed Eye	❑	❑	_____
Diabetes	❑	❑	_____
Hypertension	❑	❑	_____

Social History

	No	Yes	
Alcohol Use	❑	❑	_____ glass/wk
Narcotic Use	❑	❑	_____
Tobacco Use	❑	❑	_____ pack/day
How long have you used?			_____ years
How long have you QUIT?			_____ years

Exposed or infected with? ❑HIV ❑Hepatitis ❑STD

List of Medications

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Notice of Privacy Practices (HIPAA)

I authorize Horner Eye Care, LTD to release any information including diagnosis and the records of any treatment of me or dependent, during the period of care, to third party payers and/or health care practitioners. I acknowledge that I have read the HIPAA Policy. It is your responsibility to pay any deductibles, co-pays, or any balance not paid by the insurance.

_____ ____/____/20____

Patient Signature (Guardian of minor) *Date*