# PATIENT MEDICAL HISTORY

Last Name:_____ First:_____ MI:_____

Address: _____ City _____ State _____ Zip _____

Home Phone (  )_____ Work (  )_____ Cell (  )_____

e-mail: _____ DOB: _____/_____/_____ SSN:_____-_____-_____

Occupation:_____ Last Eye Exam: _____/_____ by Dr._____

Employer:_____ Last Medical Exam: _____/_____ by Dr._____

Guarantor :_____ DOB: _____/_____/_____ SSN:_____-_____-_____

Patient Relation to Insured: [ ]Child [ ]Spouse [ ]Dependent Insured's Employer:_____

| List of Medications (Including Eye Drops) | *Dose/Freq.* | *Used for treatment of:* |
|---|---|---|
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| | | ***If YES, please explain:*** |
| Do you have **ALLERGIES** to any Medications? | [ ]NO [ ]YES | *rash/congestion/anaphylaxis* |
| **ALLERGIES:** *Hay fever, Sinusitis, Rhinitis, Itchy Eyes* | [ ]NO [ ]YES | |
| **CARDIOVASCULAR:** *Hypertension, Heart Disease, Vascular Disease/Stroke* | [ ]NO [ ]YES | |
| **CONSTITUTIONAL:** *Fever, Weight loss/gain, Dizziness* | [ ]NO [ ]YES | |
| **ENDOCRINE:** *DIABETES (Insulin/Oral) Controlled ? Thyroid or Adrenal dysfunct., High Cholesterol, Gout* | [ ]NO [ ]YES | |
| **EYES:** *Surgery? Glaucoma, Lazy Eye, Macular Degen.* | [ ]NO [ ]YES | |
| **GASTROINTESTINAL:** *GERD, IBS, Ulcer, Gallbladder* | [ ]NO [ ]YES | |
| **GENITOURINARY:** *Prostate, Uterine, Kidney, Bladder* | [ ]NO [ ]YES | |
| **HEAD:** *Hearing loss, Sore throat, Coughing, Vertigo* | [ ]NO [ ]YES | |
| **HEMATOLOGIC / LYMPHATIC** *Anemia, Blood Clots, Leukemia, Hodgkin, Breast Cancer* | [ ]NO [ ]YES | |
| **IMMUNE:** *Infection, Herpes, Lyme, Sjogrens, Autoimmune* | [ ]NO [ ]YES | |
| **INTEGUMENTARY (SKIN)** *Acne, Rosacea, Lupus, Eczema, Dermatitis, Carcinoma* | [ ]NO [ ]YES | |
| **MUSCULOSKELETAL:** *Arthritis, Marfans, MD, Muscle Pain* | [ ]NO [ ]YES | |
| **NEUROLOGICAL** *Head Ache, Seizures, MS, MG, CP, Memory Loss, Fainting* | [ ]NO [ ]YES | |
| **PSYCHIATRIC:** *Depression, Anxiety, Bi-Polar, ADD, Autism* | [ ]NO [ ]YES | |
| **RESPIRATORY:** *Asthma, COPD, TB, Lung Disease* | [ ]NO [ ]YES | |

FAMILY HISTORY: Do any medical or eye diseases run in your family? *If YES, please note the relationship.*

[ ] Glaucoma _____ [ ] Blindness _____ [ ] Macular Degeneration_____

[ ] Diabetes _____ [ ] High blood pressure_____ [ ] Other_____

SOCIAL HISTORY: *If YES, how much.*

Do you currently use Tobacco? [ ] NO [ ] YES _____ packs/day

How long have you used Tobacco? _____ years

How long have you QUIT Tobacco? _____ years

Do you use Illegal Drugs? [ ] NO [ ] YES _____

Do you currently use Alcohol? [ ] NO [ ] YES _____ glass/wk

I authorize Horner Eye Care, Ltd. to release any information including diagnosis and the records of any treatment of me, or my child, during the period of eye care to third party payers and/or health care practitioners. I acknowledge that I have read the NOTICE of PRIVACY PRACTICES (HIPAA).

X_____/____/___