PATIENT HISTORY FORM

Mr.__ Mrs.___Ms.__ Last Name__________________________ First Name_________________ ______Date______________
DOB______________Age___ Sex__ Ethnicity_______________Race_______________Preferred Language_________________
Address____ City_______________State_____________ Zip_________________
Home Phone__________________________ Cell Phone_____________________ Email________________________________
Occupation/Employer________________________________ Work Phone ____
Primary Care Physician ________________________________ Physician's Phone____
Medical Insurance Company ___________________________ ID Number____
Subscriber's Last Name____________________________ First Name_____________________ DOB_____________________
Vision Insurance Company__________________________ ID Number ____

Reason Foe Visit Today____
List all medications you are using (including oral contraceptives, aspirin and NSAIDs, OTC medications, vitamins & herbal supplements):

Allergies to: Medications__________________________ **Pets**__________________________ **Seasonal/Environmental**____
Pregnant or Lactating? ___________ **Do you smoke cigarettes regularly**? _________________ **Consume Alcohol**? **None** _____ **Daily** _____ **Social** _________________

Review of Systems: have you been diagnosed with or treated for any of the following conditions? Please circle any of the following as applies
Neurological: Headache Migraines Seizure Paralysis Stroke Head Trauma, Multiple Sclerosis TIA Concussion
Endocrine: Thyroid Disorder (Hypo or Hyper) Pituitary Diabetes Mellitus (Juvenile or Type I Adult onset or Type III) Prediabetic
Respiratory: Asthma Emphysema Sarcold Tuberculosis Lung Cancer Asbestosis COPD
Vascular/cardiovascular: Hypertension Heart Condition Circulatory Problems Stroke Aneurism Elevated Cholesterol
Ear, Nose & Throat: Food Allergy Sinusitis Dry Throat Dry Mouth Tinnitus Seasonal Allergy Vertigo
Gastrointestinal: GERD Peptic Ulcer Inflammatory Bowel Disease Tumor Obstruction Chronic Constipation/Diarrhea
Musculoskeletal: Osteoarthritis Chronic Fatigue Muscle Pain Joint Pain Fibromyalgia Ankylosing Spondylitis Myasthenia Gravis
Psychiatric/Behavioral: Chemical Imbalance Depression Drug Dependence Behavioral Disorder Hyperactivity Attention Disorder
Urological/Reproductive: Prostate Cancer BPA Reproductive Hormonal Imbalance Kidney Stones STDs Viral Chlamydia Herpes
Hematological/Immunologic: Chronic Anemia Acne Rosacea Urticarial Chronic Rash Keloid Formation
Ophthalmologic: Cataract Glaucoma Macular Degeneration Iritis Strabismus Amblyopia Lazy Eye Ocular Tumor Dry eye

Family History (Please, indicate which family member)
Ocular: Blindness (disease/injury) Cataract Glaucoma Macular Degeneration Retinal Detachment Retinal Disease Strabismus
Systemic: Diabetes Heart Disease Hypertension Thyroid Disease Stroke

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 act as my agent in helping me obtain payment of my insurance and/or Medicare benefit, and I authorize payment of these benefits directly to Dr. Charles Fitzpatrick, O.D. and/ or Dr. Alan Siedman, O.D. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance overage 9as indicated in Itrem 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.

Patient Signature: ____

How did you learn about our office? Personal Recommendation Dr. Referral Insurance Directory Live nearby Website Search Yellow Pages