St. Clair Eye

Medical History Record

Name: _____ Date: _____
Last First MI

D.O.B._____ Age:_____ Last Exam: _____ Previous Eye Dr._____

Personal Medical Information: Do you have problems with any of these systems?
If yes, please check box:

- ❑ Gastrointestinal
- ❑ Ear/Nose/Throat
- ❑ Cardiovascular
- ❑ Respiratory
- ❑ Headaches
- ❑ Surgeries (what & when)
- ❑ Allergic/Immunologic
- ❑ Nervous System
- ❑ Genitourinary
- ❑ Musculoskeletal
- ❑ Skin
- ❑ Psychological
- ❑ Endocrine (Glands)
- ❑ Blood Pressure
- ❑ Diabetes (type) _____

_____

Any allergic reactions to medications or other substances? Yes ☐ No ☐

If yes, please list_____

Primary Care Physician_____Phone _____

Please check Yes or No:

Do you smoke? Yes ☐ No ☐ How much?_____
Do you drink alcohol? Yes ☐ No ☐ How much?_____
Do you take medications? Yes ☐ No ☐ List names _____

_____

Do you have family history of any of the following? If yes, please check box:

- ❑ Diabetes Relation_____
- ❑ Cataracts Relation_____
- ❑ Glaucoma Relation_____
- ❑ Macular Degeneration Relation_____
- ❑ Retinal Detachment Relation_____

Do you have any of the following? If yes, please check box:

- ❑ Dry Eyes
- ❑ Blurred Vision
- ❑ Eye Injuries
- ❑ Eye Surgeries
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Wear Contacts
- ❑ Wear Glasses

Please explain: _____

Do you have any eye problems at this time? Please explain: _____

_____

Are you interested in: Contact Lenses ☐ Glasses ☐ Sunglasses ☐ Laser Correction ☐ Sports / Safety ☐

If the above information is correct, please sign below:

Signature _____ Date_____

IMPORTANT INSURANCE NOTICE

Due to the constant changes in health insurance coverage it is impossible for us to know when you have had a change in your individual policy. **THEREFORE, IT IS NECESSARY TO REMIND YOU THAT IT IS YOUR RESPONSIBILITY TO BE INFORMED REGARDING YOUR INSURANCE COVERAGE.** It is important to remember that your insurance contract is between you and your insurance company. This office has no control over the rules and regulations dictated by the insurance companies, including the collection of copays and deductables nor the requirement for a referral. In order to bill your insurance we must maintain an agreement with them as well which requires that we collect all copays and deductables and that we obtain a referral when necessary. We must do this to continue the privilege of billing on your behalf. Therefore, if your insurance requires a copay or deductable, it will be expected at the time of your visit. Thank you for your cooperation.

9/1/10