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PATIENT HISTORY

[Please Print] DATE _____

MR / MRS / MS _____ DATE OF BIRTH _____

PREFERRED NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

MAILING ADDRESS (If different) _____

CITY _____ STATE _____ ZIP _____ SOCIAL SECURITY # _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____

MOBILE PHONE (_____) _____ EMAIL _____ @ _____

EMERGENCY CONTACT _____ PHONE (_____) _____

EMPLOYER _____ OCCUPATION _____

PRIMARY PHYSICIAN _____ PHONE (_____) _____

OPTOMETRIST _____ CITY: _____

REFERRED BY _____

PHARMACY _____ PHONE (_____) _____

Questions relating to the Patient Protection and Affordable Care Act (ACA) 2010:

PREFERRED LANGUAGE: _____

ETHNICITY: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Decline to answer ___ Unknown

RACE ___ American Indian ___ Alaska Native ___ Asian ___ Black or African American
___ Native Hawaiian ___ Other Pacific Islander ___ White ___ Decline to answer ___ Unknown

INSURANCE: 1. _____ 2. _____

MARITAL STATUS: SINGLE / MARRIED / WIDOWED / DIVORCED

SPOUSE / NEXT OF KIN _____ PHONE _____

HOW DID YOU HEAR ABOUT US?

INDIVIDUAL: _____ DOCTOR: _____

RADIO: ___ WOKQ ___ WHEB ___ WQSX ___ WERZ ___ WBYY (THE BAY)

NEWSPAPER: ___ FOSTER'S ___ PORTSMOUTH HERALD ___ OTHER

PAST MEDICAL HISTORY

Please CHECK if you now have or have ever had any of the following:

When the incident occurred or when the condition was diagnosed

	YES	NO	
DIABETES	_____	_____	_____
HIGH BLOOD PRESSURE	_____	_____	_____
ASTHMA	_____	_____	_____
COPD / EMPHYSEMA	_____	_____	_____
HEART ATTACK	_____	_____	_____
ANGINA	_____	_____	_____
BLEEDING DISORDER	_____	_____	_____
G.I. DISEASE	_____	_____	_____
LIVER DISEASE / HEPATITIS	_____	_____	_____
KIDNEY DISEASE / STONES	_____	_____	_____
PERIPHERAL VASC DISEASE	_____	_____	_____
TUBERCULOSIS	_____	_____	_____
IRREGULAR HEART BEAT	_____	_____	_____
CARDIAC PACEMAKER	_____	_____	_____
STROKE	_____	_____	_____
ANEMIA	_____	_____	_____
HAYFEVER	_____	_____	_____
BRONCHITIS	_____	_____	_____
PNEUMONIA	_____	_____	_____
STOMACH ULCER	_____	_____	_____
ARTHRITIS	_____	_____	_____
CANCER OR TUMOR –LOCATION	_____	_____	_____
and TREATMENT	_____	_____	_____
THYROID DISEASE	_____	_____	_____
SEIZURES	_____	_____	_____
VARICOSE VEINS /LEG BLOOD CLOTS	_____	_____	_____
HIV, AIDS, Other Blood Disorders	_____	_____	_____

Family and Social History

Among your Blood Relatives, are there any of the following:

Relative (s):

	YES	NO	
GLAUCOMA	_____	_____	_____
CATARACTS	_____	_____	_____
MACULAR DEGENERATION	_____	_____	_____
OTHER RETINAL DISEASES	_____	_____	_____
COLOR BLINDNESS	_____	_____	_____
UNEXPLAINED VISUAL LOSS	_____	_____	_____
BLINDNESS	_____	_____	_____

Past Ocular History (Past Eye History)

Have you had or been diagnosed with any of the following:

- ____ Eye Trauma – Type: _____ when: _____
- ____ Cataracts
- ____ Recurrent Corneal Erosion
- ____ Keratoconus
- ____ Allergic Conjunctivitis
- ____ Glaucoma
- ____ Corneal Ulcers
- ____ Iritis
- ____ Herpes Keratitis (Eye Condition)
- ____ Dry Eye Syndrome
- ____ Corneal Scars
- ____ Lazy or Crossed Eye(s)

Previous Eye Surgeries (please list the eye and approximately when the surgery occurred) PLEASE INDICATE IF NONE

1. _____
2. _____
3. _____
4. _____
5. _____

REVIEW OF SYMPTOMS: DO YOU HAVE THE FOLLOWING?
PLEASE CIRCLE THE APPROPRIATE SYMPTOM YOU ARE EXPERIENCING

Cardiovascular: chest pain, irregular heart beat, shortness of breath

Ear /Nose/ Throat Problems: dizziness, hearing loss, hoarseness, ringing in ears, sore throat

Neurological: balance problems, headache, numbness, tingling

Constitutional: fatigue, fever, night sweats, weakness, weight loss

Hematologic: bleeding, bruising, tender nodes

Psychiatric: anxiety, depression, insomnia, irritability, nervousness

Gastrointestinal: abdominal pain, constipation, heartburn, nausea, vomiting

Metabolic: cold intolerance, excess hunger, excessive thirst, frequent urination, heat intolerance

Respiratory: cough, trouble breathing, wheezing

Genitourinary: genital discharge, genital lesions, painful urination, urgency

Musculoskeletal: back pain, joint pain, muscle pain, stiffness, swelling

Skin: hair loss, rash, skin lesions

WHAT MEDICATIONS DO YOU TAKE REGULARLY? PLEASE INDICATE IF NONE

NAME	DOSAGE	TIMES DAILY
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____
7 _____	_____	_____

ANY EYE DROPS OR EYE MEDS? PLEASE INDICATE IF NONE

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

PREVIOUS SURGERIES:

YEAR:

- | | | |
|----|-------|-------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |
| 6. | _____ | _____ |

ALLERGIES:

SOCIAL HISTORY:

PLEASE CIRCLE THE APPROPRIATE ANSWER

SMOKING:

1. Current Everyday Smoker
2. Current Same Day Smoker
3. Former Smoker
4. Never Smoked

ALCOHOL:

1. Never
2. Rarely
3. Occasional
4. Daily
5. Frequent
6. Heavy

RECREATIONAL DRUGS:

1. Never
2. Rarely
3. Occasional
4. Daily
5. Frequent
6. Heavy

Type of Tobacco:

- Cigar
- Cigarettes
- Pipe

Type of Alcohol:

- Beer
- Liquor
- Wine

Type of Drug:

- Amphetamine
- Cocaine
- IV drugs, LSD

OCCUPATION:

- Business
- Manual Labor
- Office work
- Retired
- Student

HOBBIES:

- Computer
- Music
- Sewing
- Sports
- Travel

I hereby authorize and direct the above-named insurance company to pay benefits directly to Northeast Corneal Consultants, PA (dba Excellent Vision Eye and Laser Centers). I further authorize this office, Excellent Vision Eye and Laser Centers, to release to the above-named insurance company any medical information necessary to obtain payment for my treatment. I understand my insurance company will be billed on my behalf and I am responsible for all fees, deductibles, co-payments, and any unpaid portion of my bill.

I certify the above information is true and correct to the best of my knowledge and will notify Excellent Vision Eye and Laser Centers of any changes of the above stated information.

Should this account go delinquent, you may be responsible for all additional fees, collection fees, attorney fees, court costs, and administration fees.

PATIENT'S SIGNATURE: _____

Date: _____

Patient's Legal Guardian (if necessary): _____

Date: _____