SEDONA EYE CARE

PATIENT MEDICAL HISTORY

ALLERGIC/REACTION _____ _____ _____	**CARDIOVASCULAR** NO_____ _____ CHOLESTEROL ELEVATED _____ HEART DISEASE _____ HIGH BLOOD PRESSURE _____ HYPERTENSION _____ MYOCARDIAL INFARCTION _____ STROKE _____ OTHER_____ MEDICATION _____	**CONSTITUTIONAL** NO_____ _____ BLACKOUTS _____ DIZZINESS _____ FATIGUE _____ FEVER _____ OTHER_____ MEDICATION _____
ENDOCRINE NO_____ _____ CROHN'S _____ DIABETES MELLITUS _____ HYPOGLYCEMIA _____ THYROID DISORDER _____ OTHER_____ MEDICATION _____	**GASTROINTESTINAL** NO_____ _____ COLITIS _____ CIRRHOSIS _____ DIGESTIVE _____ _____ ULCER _____ OTHER_____ MEDICATION _____	**GENITOURINARY** NO_____ _____ CANCER _____ _____ SEXUALLY TRANSMITTED _____ OTHER_____ MEDICATION _____ _____ PREGNANT (POSSIBLE)
EARS/NOSE/MOUTH/THROAT NO_____ _____ ENCEPHALITIS _____ HEADACHES _____ SINUSITIS _____ OTHER_____ MEDICATION _____	**HEMATOLOGIC/LYMPHATIC** NO_____ _____ ANEMIA _____ COAGULATION DISORDER _____ LEUKEMIA _____ POLYCYTHEMIA _____ OTHER_____ MEDICATION _____	**IMMUNOLOGIC** NO_____ _____ AIDS _____ DIPTHERIA _____ HERPES _____ INFLUENZA _____ OTHER_____ MEDICATION _____
INTEGUMENTARY NO_____ _____ BASAL CELL NEVUS SYNDROME _____ DRY SKIN _____ OCULAR ROSACEA _____ PSORIASIS _____ OTHER_____ MEDICATION _____	**MUSCULOSKELETAL** NO_____ _____ ARTHRITIS _____ MUSCULAR DYSTROPHY _____ MYASTHENIA GRAVIS _____ OSTEOPOROSIS- EARLY / ADVANCED _____ OTHER_____ MEDICATION _____	**NEUROLOGICAL** NO_____ _____ HEADACHE _____ MULTIPLE SCLEROSIS _____ SEIZURE DISORDER _____ TRIGEMINAL NEURALGIA _____ OTHER_____ MEDICATION _____
PSYCHIATRIC NO_____ _____ ANXIETY DISORDER _____ DEPRESSION _____ SCHIZOPHRENIA _____ OTHER_____ MEDICATION _____	**RESPIRATORY** NO_____ _____ ASTHMA _____ BRONCHITIS _____ LUNG DISEASE _____ SMOKER _____ OTHER_____ MEDICATION _____	**ADDITIONAL MEDICATIONS** _____ _____ _____
EYES NO_____ _____GLAUCOMA _____CATARACT _____MACULA DEGENERATION MEDICATION_____ _____ SUPPLEMENTS_____ _____ _____	**FAMILY HISTORY** NO_____ **_____GLAUCOMA** MOTHER FATHER SISTER BROTHER MATERNAL: GRANDMOTHER FATHER PATERNAL: GRANDMOTHER FATHER **_____MACULA DEGENERATION** MOTHER FATHER SISTER BROTHER MATERNAL: GRANDMOTHER FATHER PATERNAL: GRANDMOTHER FATHER **_____DIABETES** MOTHER FATHER SISTER BROTHER MATERNAL: GRANDMOTHER FATHER PATERNAL: GRANDMOTHER FATHER	**SOCIAL** **DO YOU DRINK ALCOHOL?** ____ YES ____ NO IF YES: SOCIAL 1 A DAY 2-3 A DAY 4+ A DAY **DO YOU SMOKE?** ____ YES ____ NO IF YES: OCCASIONALLY ½ PACK A DAY 1 PACK A DAY MORE THAN 1 PACK A DAY **DID YOU USE TO SMOKE?** ____ YES ____ NO HOW LONG AGO?_____

Patients are responsible for all services rendered, regardless of whether or not they have insurance. Payments are to be made when services are rendered unless other arrangements have been made. Please note that medical insurance/Medicare do not cover refractions and will be collected on your day of service. If your insurance requires an authorization/referral to be seen in to our office it is your responsibility to arrange this with your Primary Care Physician (PCP). It is impossible to obtain such documentation without you seeing your PCP prior to your visit. There is a $25.00 charge added on for all returned checks.

By signing below, you agree to these terms and to pay any and all reasonable collection cost. Insurance/Medicare Lifetime Authorization. I request that payment under my insurance program be made either to me or to the provider name above on any bill for services furnished to me during the effective period. I authorize the above named provider to release to my insurance company or intermediaries or carriers any information needed for this claim or a related insurance claim.

Signature_____Date_____