Medical History Record

Home #_____

Name:_____Cell #_____

Address: _____ Zip Code: _____

Birth Date: _____/_____/_____ E-mail: _____

Place of Employment: _____Work #_____

Vision Insurance: _____S.S.N./ID# _____

Medical Insurance: HMO/PPO _____ ID # _____

Personal Medical Information: Which of the following conditions do you experience? Please check all that apply

High Blood Pressure	□	Neuropathy	□	Depression	□
Diabetes Type ___	□	Seasonal Allergies	□	Gastrointestinal Disease	□
Heart Disease	□	Rheumatoid Arthritis	□	Genitourinary Disease	□
Asthma	□	Skin Conditions	□		

Other Medical Conditions: _____

Date of your last routine eye examination: _____

Do you have allergic reactions to medications or other substances? Yes □ No □

If yes, please list? _____

Name of Family/Primary Doctor _____ Date of last visit _____

Please check Yes or No

Do you smoke? Yes □ No □ how much? _____

Do you drink alcohol? Yes □ No □ how much? _____

Do you take medication? If yes, please list _____

Do you have family history of any of the following? If Yes, please check all that apply

High blood pressure	□	Macular degeneration	□	Cataracts	□
Diabetes	□	Retinal detachment	□	Glaucoma	□

Please explain any boxes you have checked_____

_____

Do have any of the following? If Yes, please check all that apply

Dry Eyes	□	Eye Surgeries	□	Wear Glasses	□
Eye Injuries	□	Blurred Vision	□	Wear Contacts	□

Whom may we thank for referring you? _____

I hereby assign all medical benefits, to include all major medical benefits to which I am entitled, including Medicare, Medical, private insurance, and any other health plans to Dr. Victor Bautista and Dr. Katherine Stout, Eyes on Twenty-Fourth Optometry. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. I agree that I am responsible for my bill regardless of whether my insurance pays or denies my claim.

Patient's Signature: _____ Date: _____ Doctor's initials ____

Relationship to patient (if signed by a personal representative of patient): _____