Welcome To Our Office

Medical History Record

Name: _____ Birth Date: ____/____/____ Age: ____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell: (____) _____ Sex: ____ Marital Status: ___

Social Security No._____ E-mail:_____

Race (Check One):
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Caucasian/ White
☐ Hispanic/ Latino
☐ Native Hawaiian/ Other Pacific Islander

Preferred Language:
☐ English
☐ Spanish
☐ Japanese
☐ Other_____

How should we contact you?
☐ Phone
☐ Email
☐ Postal

Employer: _____ Occupation: _____

Work Phone: _____

Notify In Case Of Emergency: _____Phone: _____

Relationship: _____

Family Doctor: _____ Phone: _____

Date of last physical: _____ Height: _____ Weight: _____

Referring Doctor: _____ Phone: _____

List all medications, dosage & reason for taking: (Prescription and Over-the-Counter) Attach list if necessary.

(Name & Dosage)	(Reason for taking)	(Name & Dosage)	(Reason for taking)
(1)		(7)	
(2)		(8)	
(3)		(9)	
(4)		(10)	
(5)		(11)	
(6)		(12)	

Pharmacy: _____

Do you have allergies to any medications? Yes ☐ NO ☐ If YES, List medications and **reactions**:

_____

_____

Insurance Information (Please provide us with your card and driver's license)

Name of Insurance: _____ Name of Cardholder: _____

ID#:_____ Group#: _____

Cardholder's date of birth: _____ Cardholder's Social Security No: _____

Cardholder's Employer: _____

What is the purpose of your visit today? Routine ☐ Problem ☐ if so please explain: _____

_____

Review of Systems

Do you presently have any problems in the following areas?

Allergic/Immunologic	**YES**	**NO**
Seasonal allergies	☐	☐
Immune problems	☐	☐
General allergies	☐	☐
Other_____		

Gastrointestinal (Stomach/Intestines)	**YES**	**NO**
Jaundice/Hepatitis	☐	☐
Ulcers/Bleeding	☐	☐
Hiatus Hernia	☐	☐
IBS	☐	☐
Acid Reflux	☐	☐
Other_____		
Cancer_____		

Integumentary (Skin and/or Breast)	**YES**	**NO**
Psoriasis	☐	☐
Acne Rosacea	☐	☐
Lupus	☐	☐
Other_____		
Cancer_____		

Respiratory (Lungs/ Breathing)	**YES**	**NO**
Asthma	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Lung Cancer	☐	☐
Sarcoidosis	☐	☐
COPD	☐	☐
Cystic Fibrosis	☐	☐
Other_____		

Cardiovascular	**YES**	**NO**
Congestive heart failure	☐	☐
Heart murmur	☐	☐
Heart attacks	☐	☐
Heart Palpations	☐	☐
Blood pressure	☐	☐
Chest pain/angina	☐	☐
Other_____		

Genitourinary (Genitals/Kidney/Bladder)	**YES**	**NO**
Kidney disease	☐	☐
Kidney Stones	☐	☐
Other_____		
Cancer_____		

Musculo-Skeletal	**YES**	**NO**
Degenerative arthritis	☐	☐
Rheumatoid arthritis	☐	☐
Muscle/ Joint pain	☐	☐
Fibromyalgia	☐	☐
Scoliosis	☐	☐
Osteoporosis	☐	☐
Other_____		

Constitutional Symptoms	**YES**	**NO**
Fever	☐	☐
Weight Loss	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Disorientation	☐	☐
Other_____		

Head (Ear, Nose, Mouth, Throat)	**YES**	**NO**
Hearing problems	☐	☐
Sinus congestion	☐	☐
Headaches	☐	☐
Chronic cough	☐	☐
Dry throat/mouth	☐	☐
Other_____		

Neurological	**YES**	**NO**
Migraines	☐	☐
Seizures	☐	☐
Stroke/Paralysis	☐	☐
Vertigo	☐	☐
Bell's Palsy	☐	☐
Epilepsy	☐	☐
Multiple Sclerosis	☐	☐
Muscular Dystrophy	☐	☐
Neurofibromatosis	☐	☐
Other_____		

Endocrine	**YES**	**NO**
Diabetes	☐	☐
How Long?_____		
Today's Reading_____		
Pancreatic Cancer	☐	☐
Crohn's Disease	☐	☐
Thyroid Disorder	☐	☐
Hormone Replacement	☐	☐
Elevated Cholesterol	☐	☐
Hyperthyroidism	☐	☐
Other_____		
Cancer_____		

Hematologic/Lymphatic	**YES**	**NO**
Anemia	☐	☐
Sickle Cell disease	☐	☐
Leukemia	☐	☐
Other_____		
Cancer_____		

Psychiatric	**YES**	**NO**
Depression	☐	☐
Schizophrenia	☐	☐
Bipolar	☐	☐
ADD	☐	☐
Alzheimer's	☐	☐
Anxiety Disorder	☐	☐
Autism	☐	☐
Dementia	☐	☐
Other_____		

Past History

List any major illneses and injuries you have had in the past:

_____

_____

List any significant eye history (i.e.: cataracts, macular degeneration, glaucoma, injuries to eyes) you have had:

_____

_____

List <u>any surgeries</u> you have had in the past including approximate date of surgery:

_____

_____

Family History (M=mother, F=father, B= brother, S= sister, GP=grandparent)

Patient	Family	If Family, what relation to you	Patient	Family	If Family, what relation to you
☐	☐	Glaucoma_____	☐	☐	Hepatitis_____
☐	☐	Lazy Eye_____	☐	☐	HIV +/ AIDS_____
☐	☐	Diabetes_____	☐	☐	Neurofibromatosis_____
☐	☐	High Blood Pressure_____	☐	☐	Keratoconus_____
☐	☐	Heart Disease_____	☐	☐	Lyme disease_____
☐	☐	Sarcoidosis_____	☐	☐	Graves Disease/Thyroid_____
☐	☐	Asthma/ Breathing Problems_____	☐	☐	Myasthenia Gavis_____
☐	☐	Migraine Headaches_____	☐	☐	Retinal Detachment_____
☐	☐	Lupus_____	☐	☐	Multiple Sclerosis_____
☐	☐	Cataracts_____	☐	☐	Blindness_____
☐	☐	Cataract Surgery_____	☐	☐	Retinitis Pigmentosa_____
☐	☐	Corneal Dystrophies_____			
☐	☐	Macular Degeneration_____			

Responsible Party's Information (If minor)

Name: _____ Relationship to patient: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ Work Phone: _____

Date of birth: _____ Social Security No: _____

Social History

Do you currently wear glasses? □ Yes □ No
How long have you had the current pair? _____
Do you currently wear contacts? □ Yes □ No How old are they? _____
Have you ever tried to wear contacts? □ Yes □ No
Do you drive? □ Yes □ No
Do you smoke? □ Yes □ No If YES, How many packs a day? _____
Did you quit? □ Yes □ No How long ago? _____
Do you drink alcohol? □ Yes □ No If YES, How many drinks a day/ week? _____
Do you use illegal drugs? □Yes □No
Have you ever had a blood transfusion? □ Yes □ No
Have you ever had a sexually transmitted disease? □ Yes □ No

Check any activities that you participate in:

□Desk/ Office	□Public Speaking	□Computer	□Farming/ Industrial
□Reading	□Music	□Card playing	□Needlework
□Auto Mechanics	□Driving	□Billiards	□Hunting/ Shooting
□Fishing/ boating	□Sports (List) _____		

_____

RELEASE OF INFORMATION:

I hereby authorize Dr. Linda Neuhoff, O.D. to disclose or obtain all or any part of my or my dependent's records to or from any person or corporation which may be liable for all or part of the charges of Dr. Linda Neuhoff, O.D., including but not limited to insurance companies, employers or employees of Dr. Linda Neuhoff, O.D.

ASSIGNMENT OF BENEFITS:

I hereby assign all medical benefits covered by my insurance to Dr. Neuhoff for her services rendered. I understand that I am financially responsible for all charges incurred and not covered by insurance.

Acknowledgement of Notice of Privacy Practices (HIPPA):

I acknowledge that I have been given or offered a copy of Dr. Linda S. Neuhoff's Notice of Privacy Practices. This Notice discloses my protected health information, certain restrictions on the use and disclosure of my healthcare information, and the rights I may have regarding my protected health information.

X

Signature of Patient (Personal Representative) Date Relationship to Patient