Pediatric Eye Associates

PATIENT'S PERSONAL HISTORY

PATIENT

Patient's Last Name	First Name (legal)	Middle Name	Nickname

Address	City	State	Zip	Home Phone

Age	Date of Birth	Sex F ( ) M ( )	SS# (Required)

☐ ***SELF***

Employer	Occupation	Work e-mail		Work Phone ( )
Employer Address	**City**	**State**	**Zip Code**	**Cell Phone (or other)** ( )
Home e-mail				

☐ ***SPOUSE***

Name (Last)	First	M.I.	Date of Birth	Social Security Number

Home/Mailing Address	City	State	Zip Code	Home Phone ( )
Employer	**Occupation**	**Work e-mail**		**Work Phone** ( )
Employer Address	**City**	**State**	**Zip Code**	**Cell Phone (or other)** ( )
Home e-mail				

EMER-GENCY

Name of Relative or Authorized Person to Notify in Case of an Emergency	Relationship	Home Phone ( )

Street Address	City	State	Zip Code	Work Phone ( )

Primary Care Physician: _____

Who referred you to our practice: _____

Please provide a current insurance card for the receptionist.
All copays are due at the time of service.

I also realize that if I am turned over to a collection agency to obtain payment for services rendered, I will be responsible for legal collection fees. We will not be involved in legal disputes.

_____ _____ _____

Signature Relationship Date

HEALTH HISTORY

Date Information Verified/By:	

PATIENT NAME

CONFIDENTIAL INFORMATION

HEALTH HISTORY	YES	NO
1. Cancer	☐	☐
2. Diabetes	☐	☐
3. Heart Disease	☐	☐
4. Heart Attack	☐	☐
5. Rheumatic Fever	☐	☐
6. Congenital	☐	☐
7. High Blood Pressure	☐	☐
8. Palpitations/Flutter	☐	☐
9. Pacemaker	☐	☐
10. Respiratory Disease	☐	☐
11. Chronic Cough	☐	☐
12. Hay Fever	☐	☐
13. Shortness of Breath	☐	☐
14. Asthma	☐	☐
15. Positive TB Test	☐	☐
16. Seizures/Strokes	☐	☐
17. Loss of Consciousness	☐	☐
18. Bleeding Tendency	☐	☐
19. Digestive Disease	☐	☐
20. Colitis	☐	☐
21. Stomach Ulcers	☐	☐
22. Hiatal Hernia / Reflux	☐	☐
23. Liver Disease	☐	☐
24. Genital / Urinary	☐	☐
25. Kidney Disease	☐	☐
26. Difficulty Voiding	☐	☐
27. Menstrual Difficulties	☐	☐
28. Sexual Dysfunction	☐	☐
29. Arthritis	☐	☐
30. Goiter/Thyroid Disease	☐	☐
31. Migraine Headache	☐	☐
32. Mental Illness	☐	☐
33. Depression	☐	☐
34. Nervous Breakdown	☐	☐

ALLERGIES

(Drug or other)

Latex Rubber: ☐ Yes ☐ No ☐ Unknown

Shellfish: ☐ Yes ☐ No ☐ Unknown

X-Ray Dye: ☐ Yes ☐ No ☐ Unknown

MEDICATIONS
(List medications, including aspirin, laxatives, birth control pills, cough meds, all prescriptions)

NAME	DOSE	FREQUENCY	LAST DOSE

FAMILY HISTORY	Sex	Age	ILLNESS OR CAUSE OF DEATH
Father			
Mother			
Brothers/Sisters* *(Circle Sex)*			
	M F		
	M F		
Husband/Wife			
Sons/Daughters* *(Circle Sex)*			
	M F		
	M F		

HEALTH HISTORY	YES	NO	
Previous Hospitalization	☐	☐	
Previous Surgery(ies)	☐	☐	
Serious Illness	☐	☐	
Serious Injury(ies)	☐	☐	
History of Problems with Anesthesia:			
Self	☐	☐	
Family	☐	☐	
Steroids	☐	☐	
Transfusion Reaction	☐	☐	
Pregnant	☐	☐	

CONFIDENTIAL INFORMATION

COMMENTS

PERSONAL HABITS ***(Check appropriate box)***

☐ Yes ☐ No Do you regularly smoke? ☐ Cigarettes ☐ Pipe ☐ Cigars For how many years?_____ How many?_____

☐ Yes ☐ No Do you usually drink over 6 cups of coffee per day?

☐ Yes ☐ No Do you regularly drink alcohol? ☐ 1 oz. per day ☐ 2 oz. per day ☐ 4 oz. per day ☐ over 6 oz. per day

BEER: ☐ 1 bottle per day ☐ 2 bottles per day ☐ over 4 bottles per day

☐ Yes ☐ No Do you have difficulty in falling asleep? If yes, how often?

☐ Yes ☐ No Do you exercise regularly?