LIVE OAK
OPHTHALMOLOGY
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PATIENT HISTORY QUESTIONNAIRE

NAME:_____ DATE:_____

PAST MEDICAL HISTORY: Do you have any of the following conditions?

	yes	no		yes	no		yes	no
High Blood Pressure			Arthritis			Cancer		
Diabetes			Anemia			Seizures		
Heart Disease			Thyroid Disease			Kidney Disease		
Asthma			Stroke			Migraine		

ANY OTHER MEDICAL PROBLEMS:_____

FAMILY HISTORY: Do you any members of your family have a history of the following conditions?

	yes	no		yes	no		yes	no
Glaucoma			Macular Degeneration			Stroke		
Cataract			Diabetes			Cancer		
Retinal Detachment			High Blood Pressure			Arthritis		
Sudden Vision Loss			Heart Disease			Asthma		

PAST SURGICAL HISTORY:

◯ no previous surgery

Eye Surgery:	Other Surgery:

MEDICATIONS:

◯ no medications

Eye Meds:	Other Meds by Mouth:

ALLERGIES: Please list any medications you are allergic to:

◯ no known allergies

SOCIAL HISTORY:

Do you smoke? yes no (if yes, how much?)_____
Do you drink alcohol? yes no (if yes, how much?)_____
Any use of "street drugs"? yes no
Do you drive? yes no
What hobbies do you enjoy?_____

Continue on Back

PATIENT HISTORY QUESTIONNAIRE

NAME:_____ DATE:_____

REVIEW OF SYSTEMS: if you are **CURRENTLY** having any problems in the following areas, please circle.

SKIN: itching, rash, ulcer, tumors (growths), other ◯none

LYMPH NODES: swelling, tenderness ◯none

BONES, JOINTS, MUSCLES: muscle pain/cramps, joint pain/swelling, other ◯none

ENDOCRINE: fatigue, confusion, fainting, nervousness, hot/cold intolerance, hair loss, other ◯none

ALLERGY/IMMUNOLOGY: recurrent infections, hayfever, hives, food allergy, drug sensitivity, other ◯none

HEAD: headaches, dizziness, vertigo, other ◯none

EARS: hearing loss, ringing, infections, other ◯none

NOSE: bleeding, loss of smell, congestion, sinus problems, other ◯none

THROAT: dry mouth, loss of taste, difficulty swallowing, hoarseness, jaw pain, other ◯none

NECK: pain, swelling, stiffness, other ◯none

BREASTS: tenderness, swelling, lumps, discharge, other ◯none

BLOOD: fever, chills, bruise easily, prolonged bleeding, skin hemorrhages, blood loss, other ◯none

RESPIRATORY: wheezing, cough (productive/blood), difficulty breathing, asthma, other ◯none

CARDIOVASCULAR: (heart/blood vessels): chest pain, swelling of extremities, shortness of breath exercise intolerance, palpitations, other ◯none

GASTROINTESTINAL: (stomach/intestines): nausea, vomiting, change in bowel habits, constipation, diarrhea pain/cramps, bleeding, other ◯none

GENITOURINARY: frequency, burning, hesitancy, pain or bleeding on urination, infections, incontinence, impotence, other ◯none

NERVOUS SYSTEM: weakness in arms or legs, numbness or tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other ◯none

PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations, other ◯none

THIS FORM COMPLETED BY: PATIENT FAMILY STAFF

FOR OFFICE USE ONLY
HISTORY AND ROS REVIEWED

1. [ ] NO CHANGES	[ ] ADDITIONS AS NOTED ABOVE	DATE: _____	INITIALS _____
2. [ ] NO CHANGES	[ ] ADDITIONS AS NOTED ABOVE	DATE: _____	INITIALS _____
3. [ ] NO CHANGES	[ ] ADDITIONS AS NOTED ABOVE	DATE: _____	INITIALS _____
4. [ ] NO CHANGES	[ ] ADDITIONS AS NOTED ABOVE	DATE: _____	INITIALS _____
5. [ ] NO CHANGES	[ ] ADDITIONS AS NOTED ABOVE	DATE: _____	INITIALS _____
6. [ ] NO CHANGES	[ ] ADDITIONS AS NOTED ABOVE	DATE: _____	INITIALS _____
7. [ ] NO CHANGES	[ ] ADDITIONS AS NOTED ABOVE	DATE: _____	INITIALS _____
8. [ ] NO CHANGES	[ ] ADDITIONS AS NOTED ABOVE	DATE: _____	INITIALS _____
9. [ ] NO CHANGES	[ ] ADDITIONS AS NOTED ABOVE	DATE: _____	INITIALS _____

LIVE OAK OPHTHALMOLOGY, PC

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

Yes No Home Phone: _____ Yes No Cell Phone: _____

May we contact you at your place of employment? Yes No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family member(s) that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

Yes No If yes, please provide:

Name: _____ Relationship: _____

Phone: _____ Alternate Number: _____

Name: _____ Relationship: _____

Phone: _____ Alternate Number: _____

Do you have a Power of Attorney for medical purposes? Yes No

If you have a Power of Attorney, please attach copy of documentation.

I hereby authorize Live Oak Ophthalmology to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Life Oak Ophthalmology's Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witnessed by: _____

Live Oak Ophthalmology

1915 S. 17th Street

Wilmington, NC 28401

910.251.8200 Phone / 910.251.8204 Fax

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____

Address: _____

_____

Telephone: _____

I am requesting my records be sent FROM: _____

Please send records TO: _____

Address: _____

_____

Phone: _____ Fax: _____

Covering the period of healthcare from _____ to _____

I understand this could include information about AIDS, HIV, behavioral or psychiatric care or drug use.

I understand that this authorization may be revoked in writing at any time.

The facility, employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information.

Signed: _____ Date: _____

Or Legal Representative: _____ Date: _____

Signature of Witness: _____ Date: _____