PATIENT MEDICAL HISTORY FORM

NAME:_____**DATE:**_____

MAIN EYE PROBLEM:

_____

_____

_____

Which eye is affected: _____ **Onset:** gradual/ sudden/ unsure **For how long:** _____

Severity: Mild / Moderate / Severe **Course:** improving/ worsening/ staying the same/ unsure

Associated signs or symptoms: ❑ Pain ❑ Redness ❑ Itching ❑ Dry Eyes

❑ Dark spots ❑ Flashing lights ❑ Wavy lines ❑ Double vision

EYE HISTORY:

❑ Retinal Detachment
❑ Diabetic Eye Problems
❑ Glaucoma
❑ Macular Degeneration
❑ Cataract Removal
❑ Laser Eye Treatment
❑ Eye injections
❑ Eye injury

EYE DROPS/ MEDICATION:

_____

_____

MEDICAL HISTORY:

❑ Diabetes If so, year diagnosed?_____ If you're on Dialysis, which days?_____
What is was your most recent blood sugar reading?_____
What is your last AIC (blood test) reading?_____

❑ Hypertension ❑ Arthritis
❑ High Cholesterol ❑Cancer: _____
❑ Heart Disease ❑Stroke:_____/_____(year/side affected)
❑ OTHER:_____

Flu Vaccine ❑ Yes ❑ No Date: _____
Pneumonia Vaccine ❑ Yes ❑ No Date:_____
COVID19 Vaccine ❑ Yes ❑ No How many doses:_____

	GENERAL OPERATIONS			EYE OPERATIONS	
	Type	*Year*		*Type*	*Year*
1.					
2.					
3.					
4.					
5.					

6.					

CURRENT MEDICATION: _____

_____

_____

_____

_____

_____

Are you allergic to any medication? ❑ NO ❑ YES - please list _____

Any environmental or food allergies? ❑ NO ❑ YES - please list _____

FAMILY MEDICAL HISTORY- Does any of your immediate family have: Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Other:_____/ ❑ NONE

FAMILY EYE HISTORY - Does any of your immediate family have: Diabetic Blindness, Retinal Detachment, Glaucoma. Macular Degeneration, Other:_____/ ❑ NONE

SOCIAL HISTORY

Do you smoke? ❑ No ❑ Yes- how often: Frequently / Once Daily / Occasionally

Do you drink alcohol? ❑ No ❑ Yes- how often: Frequently / Once Daily / Occasionally

Do you have any history of injury or recent falls? ❑ NO ❑ YES - please list _____

SYSTEMS REVIEW:

GENERAL
- ❑ Recent weight gain/loss
- ❑ Fever
- ❑ Other:_____

EARS, NOSE, THROAT
- ❑ Drainage
- ❑ Loss of hearing
- ❑ Other:_____

MUSCLE/JOINTS/BONES
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Numbness in hands/feet
- ❑ Paralysis

STOMACH/ INTESTINES
- ❑ Nausea
- ❑ Ulcer
- ❑ Heartburn
- ❑ Other:_____

HEART AND LUNGS
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Heart murmur
- ❑ Persistent cough
- ❑ Other:_____

ENDOCRINE
- ❑ Excessive thirst
- ❑ Excessive urination

HEAD/ BRAIN
- ❑ Headaches/ Migraines
- ❑ Seizures/Convulsions

❑ Memory loss
❑ Other:_____

NOTICE TO INSURANCE COMPANY OF ASSIGNMENT

Authorization to pay medical and surgical benefits directly to attending physician

YOU ARE INSTRUCTED TO PAY BY CHECK MADE OUT AND MAILED DIRECTLY TO:

DAVID PARKS, M.D., Inc.
8920 WILSHIRE BLVD., SUITE 500
BEVERLY HILLS, CA 90211

I hereby authorize my Insurance Company to make payment directly to David Parks, M.D., Inc. I understand that the office will gladly assist me in filing a claim with my Insurance Company to help me obtain reimbursement from my Insurance Company. However, I also understand that insurance reimbursement is a matter between me and my Insurance Company.

I realize that I am responsible for any charges not paid by my Insurance Company. I authorize the release of any medical information necessary to process the claim. A photocopy of this authorization will be considered as valid as the original.

PATIENTS SIGNATURE_____DATE_____

Note to Insurance Company:

You are hereby given notice that our patient has assigned and authorized payment of medical and surgical benefits directly to DAVID J. PARKS, M.D., INC. Please take notice that any payments not made directly to DAVID J. PARKS, M.D., INC will not satisfy contractual obligations under the policy of insurance.

This authorization may not be revoked or withdrawn under any circumstances without the written agreement of the administrator of DAVID J. PARKS, M.D., INC

I have received the notice of privacy practices for David J Parks, M.D., Inc.

PATIENTS SIGNATURE_____DATE_____