ELK RIVER EYE CLINIC

Patient Health History

Last Name _____ First Name _____ MI _____ DOB _____/_____/_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ SSN _____

Emergency Contact Name _____ Relation _____ Phone _____

Date of Last Medical Exam _____ Primary Physician/Clinic _____

Date of Last Eye Exam _____ Clinic/Eye Doctors Name _____

Employer/School _____ Occupation/School Grade _____

Sports/Hobbies _____ Number of Children _____ Ages _____

I authorize _____ ***(Relation)*** _____

to call on my behalf and/or have access to my records.

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. **I understand that I am responsible for any balance my insurance does not pay.**

Signature _____ ***Date*** _____

Reason for Visit/History

Do you wear glasses? Yes No All the time Occasionally Office Work Reading Only Driving Only

Do you wear contacts? Yes No Type _____ Replace Schedule _____

Have you ever had an eye injury? Yes No Which Eye _____

Have you ever had any eye surgeries? Yes No Reason _____

Have you taken eye medication? Yes No Reason _____

Have you ever been diagnosed with:

Cataracts Yes No When were you diagnosed? _____

Glaucoma Yes No When were you diagnosed? _____

Macular Degeneration Yes No When were you diagnosed? _____

Are you currently pregnant or nursing? Yes No

Do you have any eye issues you would like to discuss? _____

****PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE****

19022 Freeport Street NW, Suite H, Elk River, MN 55330

(763) 441-1055 elkrivereyeclinic.com

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PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK "NONE".

Cardiovascular: _____ None ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other Medications:	Endocrine: _____ None ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other Medications:	Respiratory: _____ None ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other Medications:
Constitutional: _____ None ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other Medications:	Genitourinary: _____ None ___ Kidney Disease ___ Urinary Tract Infection ___ STD-Herpetic/Chlamydia ___ Other Medications:	Psychiatric: _____ None ___ ADHD ___ Depression ___ Schizophrenia ___ Other Medications:
Neurological: _____ None ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other Medications:	Musculoskeletal: _____ None ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other Medications:	Immunologic: _____ None ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other Medications:
Hematological: _____ None ___ Anemia ___ Leukemia ___ Other Medications:	Gastrointestinal: _____ None ___ Crohn's ___ Colitis ___ Other Medications:	Ear/Nose/Throat: _____ None ___ Hearing Loss ___ Upper Respiratory Infection ___ Other Medications:
Dermatological: _____ None ___ Eczema ___ Rosacea ___ Psoriasis ___ Other Medications:	Allergies (List all) _____ None Drug: Environmental:	Alcohol Use Yes No Amount: Tobacco Use Yes No Amount:

Please list any medications and/or drugs that you are taking (Including herbal) that are not listed above:

Family History: Has anyone in your family (grandparents, parents, siblings, children) please specify maternal or paternal grandparent living or deceased ever been diagnosed with:

___ Blindness	Who: _____	___ Retinal Detachment	Who: _____
___ Cataracts	Who: _____	___ High Blood Pressure	Who: _____
___ Glaucoma	Who: _____	___ Diabetes	Who: _____
___ Crossed Eyes	Who: _____	___ Cancer	Who: _____
___ Macular Degeneration	Who: _____	___ Heart Disease	Who: _____

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