Meadville Ophthalmology Associates Patient Medical Form

Name: ____Home Phone#: __________________Gender: Male / Female

Address: ______________________________________City: ______________________State: _____________Zip: _____________

Date of Birth: _________________Marital Status _____________________Social Security#:_______________________

Employer: ____Work Phone#: _________________________

Primary Care Doctor: _______________________________Referring Doctor: ____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Insurance Name: _____________________	Insurance Name: _______________________
Address: ____________________________	Address: _____________________________
Policy#: _____________________________	Policy#: ______________________________
Group#: _____________________________	Group#: ______________________________
Policy Holders Name: ___________________	Policy Holders Name: ___________________
Policy Holders SS#_____________________	Policy Holders SS#______________________
Policy Holders DOB: ____________________	Policy Holders DOB: _____________________
Relationship to Patient: __________________	Relationship to Patient: __________________

Please sign below for release of information to your insurance company. Fees are due and payable on the day of your appointment. If we do not receive payment from your insurance, you will be liable for payment.

Signature: ____ Date: ______________________________

EYE HISTORY

1. Do you wear Gasses? Yes or No **2. Do you wear contacts? Yes or No**

3. Have you had eye surgery, laser treatment to the eye, or eye injury? Yes or No

If yes, please explain: ____

4.What EYE medications are you presently using? (list name and how often taken): _____________________

____

5 Do you or a relative have any of the following:

	YOU	FAMILY MEMBERS: (specify relation)	
Glaucoma	YES or NO	YES or NO	Who?: ______________________________________
Cataracts	YES or NO	YES or NO	Who?: ______________________________________
Lazy Eye	YES or NO	YES or NO	Who?: ______________________________________
Retinal Disease	YES or NO	YES or NO	Who?: ______________________________________
Mac. Degeneration	YES or NO	YES or NO	Who?: ______________________________________
Flashes / Floaters	YES or NO	YES or NO	Who?: ______________________________________
Other (specify)	YES or NO	YES or NO	Who?: ______________________________________

Meadville Ophthalmology Associates Medical History

1. Do you or a blood relative have any of the following:

	YOU	FAMILY MEMBER (Specify relation)	
Diabetes	YES or NO	YES or NO	Who? ______
Heart Problems	YES or NO	YES or NO	Who? ______
High Blood Pressure	YES or NO	YES or NO	Who? ______
High Cholesterol	YES or NO	YES or NO	Who? ______
Stroke	YES or NO	YES or NO	Who? ______
Anemia	YES or NO	YES or NO	Who? ______
Emphysema	YES or NO	YES or NO	Who? ______
Asthma	YES or NO	YES or NO	Who? ______
Stomach Ulcer	YES or NO	YES or NO	Who? ______
Lupus	YES or NO	YES or NO	Who? ______
Arthritis	YES or NO	YES or NO	Who? ______
Rheumatoid Arthritis	YES or NO	YES or NO	Who? ______
Thyroid Disease	YES or NO	YES or NO	Who? ______
Cancer	YES or NO	YES or NO	Who? ______
Seizures	YES or NO	YES or NO	Who? ______
Migraines	YES or NO	YES or NO	Who? ______
Other (specify)	YES or NO	YES or NO	Who? ______

______

2. Are you allergic to any medications? Yes or NO
If yes please list medications and type of reaction: ______

______

3. What medications and/or vitamins (other than eye) do you take? List name and dosage:

______

______

______

4. What surgeries (other than eye) have you had?______

______

5. Do you smoke? YES or NO

REVIEW OF SYSTEMS

Please circle any of the following that you are currently experiencing:

GENERAL	Fever, weight loss, weight gain
EYE	Blurred vision, vision loss, loss of side vision, double vision, dryness, excess tearing,
EYE	mattering, redness, itching, burning, glare, light sensitivity, eye pain
EAR/NOSE THROAT	Sinus congestion, runny nose, dry mouth, postnasal drip
HEART	Chest pains, palpitations
LUNGS	Shortness of breath, cough
GASTROINTESTINAL	Reflux, nausea, vomiting
GENITOURINARY	Kidney stones, bladder problems, dialysis
HEMATOLOGIC/LYMPHATIC	Easy bleeding, easy bruising, swollen lymph nodes
SKIN	Rashes
NEUROLOGIC	Dizziness, headaches, memory loss
PHYCHIATRIC	Anxiety, depression
ALEERGY/IMMUNOLOGY	Sneezing, itching

Please list the names and relationships of any others that your medical condition can be discussed with: ______

______

Please list the of your Power of Attorney, if any: ______