Medical History Questionnaire

Please Note: **This is a confidential record of your medical history and will be kept in this office.**
Information contained here will not be released to any person except when you have authorized us to do so.

Patient Name: ____ Today's Date: ______/_______/__________

Address: ____ Home Phone: ________________________

City: _____________________________ Zip: ______________ Cell Phone: __________________________

New Patient____ Established____ Date of Birth: _____/_____/______ Work Phone: _________________________

Place of Employment: ___________________________________ Retired: *(circle)* Yes No Student: *(circle)* Yes No

Social Security #:__________/__________/__________ Marital Status: *(circle)* S M D W

Referred by: *(Circle)* Yellow Pages Word of Mouth Internet Other: ____

Preferred Pharmacy

Pharmacy Name: ______________________________________ Pharmacy City & Location: ____________________________

Do you have any allergies to medications? *(Circle)* Yes No If yes, please list: ______________________________

Medications *(list all medications you are taking regularly. Include over the counter, herbal or natural remedies.)*

Name of Medication	Amount/Mg	Doses/Frequency

Are you pregnant and/or nursing? *(Circle)* Yes No Last eye exam: _____/_____/______ or Months: ______________

Interested in Laser Vision Correction? *(Circle)* Yes No Have you had Laser Vision Correction? *(Circle)* Yes No

Do you wear glasses? *(Circle)* Yes No If yes, how old are your present pair of lenses? _______

Do you wear contact lenses? *(Circle)* Yes No If yes, how old are your present pair of lenses? ______

Social History

Do you drive? *(Circle)* Yes No Do you have visual difficulty when driving? *(Please explain)* ______________________________________

Current every day tobacco user ________ Former tobacco user ________ Never a tobacco user ________

Do you drink? *(Circle)* Yes No If yes, type/amount/how long: ____

Do you use illegal drugs? *(Circle)* Yes No If yes, type/amount/how long: ______________________________

Have you ever been exposed to or infected with: *(Circle)* Hepatitis HIV/AIDS None

Review of Systems ***For Patient*** (Please indicate those items that have been recurrent or recent significant change).

Yes	No	**Constitutional Symptoms**
___	___	Good health lately
		Integumentary (Skin)
___	___	Rash
___	___	Changing Moles
		Neurological
___	___	Seizure
___	___	Stroke
___	___	Headaches
		Eyes
___	___	Loss of Vision ***Right Left***
___	___	Cataracts ***Right Left***
___	___	Macular Degeneration ***Right Left***
___	___	Glaucoma ***Right Left***
___	___	PVD ***Right Left***
___	___	Retinal Tear ***Right Left***
___	___	Blepharitis ***Right Left***
___	___	Diabetic Retinopathy ***Right Left***
___	___	Allergic Conjunctivitis ***Right Left***
___	___	Eye Injury ***Right Left***
___	___	Distorted Vision/Halos ***Right Left***
___	___	Dryness ***Right Left***
___	___	Double Vision
___	___	Amaurosis Fugax (Temporary loss of vision)
___	___	Redness ***Right Left***
___	___	Excess Tearing/Watering
___	___	Eye Pain or Soreness ***Right Left***
___	___	Flashes/Floaters in Vision ***Right Left***
		Endocrine
___	___	Diabetes/Pre Diabetes
___	___	Thyroid ***(Hyper or Hypo***)/Other Glands
___	___	Kidney Disease

Yes	No	**Ear/Nose/Mouth/Throat**
___	___	Dry Throat/Mouth
___	___	Sinus Congestion
___	___	Hearing Loss
		Respiratory
___	___	Cough
___	___	Shortness of Breath
___	___	Asthma
___	___	COPD
		Vascular/Cardiovascular
___	___	Irregular/Rapid Heart Beat
___	___	High Blood Pressure
___	___	Vascular Disease
___	___	Heart Disease
___	___	Heart Attack
		Gastrointestinal/Digestive
___	___	Diarrhea
___	___	Constipation
___	___	Liver Disease
		Bones/Joints/Muscles
___	___	Rheumatoid Arthritis
___	___	Muscle/Joint Pain
		Lymphatic/Hematological
___	___	Anemia
___	___	Bleeding Problems
		Psychiatric
___	___	Anxiety
___	___	Depression
		Allergic/Immunological
___	___	Allergies ____________________
		Other
___	___	Cancer *(Please explain)*

List all major **injuries**, **surgeries** and /or **hospitalizations** you have had: ____

____

Family Medical History *(Check Yes and indicate relationship for any blood **relative** living or deceased that has had any of the following)*

Yes	No	Relationship	Disease/Condition	Yes	No	Relationship	Disease/Condition
___	___	_______	Blindness	___	___	_______	Heart Disease
___	___	_______	Cataract	___	___	_______	High Blood Pressure
___	___	_______	Glaucoma	___	___	_______	Stroke
___	___	_______	Macular Degeneration	___	___	_______	Cross Eyed
___	___	_______	Retinal Detachment/Disease	___	___	_______	Migraines
___	___	_______	Cancer	___	___	_______	Thyroid Disease
___	___	_______	Diabetes	___	___	_______	Other ______________

Person to contact in case of emergency: ____

Relationship: ___________________ Phone #: ______________________

Release of information to a spouse, family member, friend etc.

I, ____ give permission to release my past or present medical information to:
(Patient Name)

____ Phone #:_________________________
(Name released to)

Relationship: _________________ Date: _____/_____/_______

Authorization to Release Information, Assignment and Notice of Privacy Practices

I authorize James J. Harper, O.D. to release any and all information concerning my examination and treatment either verbally or in written form to appropriate insurance company(s). A copy of this authorization should be treated as if it were the original.

I certify that the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by my insurance. Outstanding insurance balances are subject to be transferred to patient or responsible party for payment after 90 days.

I have reviewed a copy of Dr. Harper's Notice of Privacy Practices.

Patient/Responsible Party: ____ Date: __________________________

(Office use only)

____ Doctor's Signature

___________________________________ Date

James J. Harper, O.D.

6018 Eastridge Rd.
Odessa, Tx. 79762
Office: 432-367-3400
Fax: 432-367-0102

Patient Name _____________________________DOB ________________

To Whom It May Concern,

I, ______________________________, give permission to release requested records to Dr. James Harper, O.D.
(Please print)

____ ___________________

Patient/Guardian Signature *Date*

Please fax the requested records to (432)367-0102 at your earliest convenience.

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Phone# ___________________________

Fax # ___________________________

Thank You.

Dr. James J. Harper O.D.