New Patient
Medical History Form

Name: _____ Date: _____

Age: _____ Sex: M F Date of Birth: _____

Email Address _____

Referred by: _____ Optometrist: _____

Family Doctor: _____ Pharmacy: _____

*Have you seen Dr. Dodds before? Yes or No
If Yes, when? _____

Answer the following questions about your medical status and health history:

Have you ever been or <u>are you being treated for any medical conditions</u> and when were you diagnosed? (Hypertension, heart disease, asthma, arthritis, diabetes, thyroid problems, cancer, etc.)

_____

_____

_____

Have you ever been <u>hospitalized, or had surgery</u>? If so, <u>when and for what reason</u>?

_____

_____

_____

Have you ever had or <u>are you being treated for any eye diseases</u>? (Glaucoma, macular degeneration, cataracts, "lazy" eye, etc.) Please list.

_____

_____

_____

Are there any <u>illnesses that run in your family</u> such as heart disease, cancer, diabetes, high blood pressure, etc? Please explain.

_____

_____

_____

Are there any <u>eye problems that run in your family</u> such as glaucoma, cataracts, macular degeneration, retina problems? Please list.

_____

_____

_____

Do you have any <u>food or drug allergies</u>? Please list

_____

_____

Have you ever had surgery to get rid of your glasses? Yes No **If yes** _____
Do you wear contact lenses? Yes No

Are you Diabetic? Yes No **If Yes, what is your current blood sugar**_____

Last time it was checked _____ **Current A1C**_____

Do you use Aspirin? Yes No Dosage_____ How many times a day? _____

Do you use Oxygen? Yes No if yes, how many liters? _____
How often_____

Do you smoke? Yes No If yes, how much _____ How many years_____

Do you consume alcohol? Yes No If yes, how much on a weekly basis? _____

Do you consume caffeine? Yes No How much daily. _____

Do you use recreational drugs? Yes No If yes what kind? _____

Review of health systems

Do you currently have any of the following *symptoms*? Circle Y or N and explain.

1. Chronic fever, unexpected weight gain or loss, unusual fatigue Y N
   Please explain: _____
2. Ear, nose or throat problems (hearing loss, sinus problems, etc.) Y N
   Please explain: _____
3. Respiratory problems (COPD, asthma, wheezing, coughing, etc.) Y N
   Please explain: _____
4. Heart problems? (Chest pain, irregular heartbeat, etc.) Y N
   Please explain: _____
5. Gastrointestinal problems (heartburn, pain, diarrhea, vomiting, etc) Y N
   Please explain: _____
6. Urinary problems (pain, discomfort, blood in urine etc.) Y N
   Please explain: _____
7. Skin problems (rashes, dryness, sores, ulcers, etc.) Y N
   Please explain: _____
8. Muscle or joint problems (muscle aches, arthritis, swollen joints, etc.) Y N
   Please explain: _____
9. Neurological problems (numbness, weakness, headaches, paralysis, etc) Y N
   Please explain: _____
10. Psychiatric problems (depression, anxiety, etc.) Y N
    Please explain: _____
11. Do you have a history of MRSA or Hepatitis? Y N
    Please explain: _____

Please explain why you are seeing the eye doctor today.

_____

_____

Please list all medications including over the counter

Medications you take:	Number of times a day:
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

Wyoming Center For Sight Date_____/_____/_____

PATIENT INFORMATION

Legal Name:_____

Birth date:_____/_____/_____ **Age:**____ **Sex:**_____ **Social Security#** _____

Mailing Address/ Street Address: _____

City _____ **State**_____ **Zip** _____

Place of Employment_____

Home Phone_____ **Cell Phone**_____ **Work Phone** _____

May we leave confidential messages on your answering machine or voicemail?

☐ Yes ☐ No

EMAIL ADDRESS:_____

Spouses Name _____ **Date of Birth** _____

Spouses Employer _____ **Home Number** _____

Cell Phone Number_____ **Work Number** _____

If the patient is a minor child: **Parent/Guardians Name** _____

Address if different then above: _____

Parent/Guardian Birth Date: _____/_____/_____ **Social Security** _____

Home Phone: _____ **Cell Phone:**_____ **Work Phone:** _____

Emergency Contact (Someone not living with you)

Name _____ **Relationship**_____

Best Contact number_____

Primary Insurance

Insurance Company _____

Medical Claims Address _____

Policy Number _____ **Group Number** _____

Policy Holders Name _____

Birth Date: _____/_____/_____ **Social Security Number:** _____

Secondary Insurance

Insurance Company _____

Medical Claims Address _____

Policy Number _____ **Group Number** _____

Policy Holders Name _____

Birth Date: _____/_____/_____ **Social Security Number:** _____

Workers Compensation

Workers Compensation# _____ **Supervisor** _____

Date of Injury_____/_____/_____ **Location** _____

Company Name _____ **Phone Number**_____

Company Address _____

City_____ **State**_____ **Zip Code** _____

*If you *do not* have a case number for workman's comp you will have 48 hours provide one. If one is not provided then you have 30 days to pay your account in full.

SIGNATURE NEEDED ON REVERSE SIDE OF THIS FORM

Additional Patient Information:

Race:
White/Caucasian
Native Hawaiian/Other Pacific Islander
American Indian/Alaska Native
Asian
Black/African American
Mixed
Unknown
Other

Language spoken:
English
Spanish
Chinese
Japanese
Russian
Other

Ethnicity:
Hispanic/Latino
Not Hispanic/Latino
Unknown

Patient declines to provide information

*** I AGREE TO THE FOLLOWING ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES.**

Our office policy requires payment in full at the conclusion of each visit.
If you have a co-pay or have not met your deductible you will be required to pay that day.
We will only bill your insurance as a courtesy.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. If I fail to keep financial agreements my account will be turned to a collection agency and I will be responsible for all collection costs as well as legal fees.

Signature _____ Date _____

Please list any Doctor, family member or individual whom we are able to discuss your medical information or treatment with. We are unable to discuss any type of care without your permission, so please list carefully.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____