



**Health History** (Completion Required by Insurance Companies)

**Do you have problems with any of these body systems? (please circle all that apply)**

Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Eyes	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic/Immunologic	Y/N

**Please Explain:** \_\_\_\_\_

**Medical-**Please answer all that apply:

Do you have diabetes? Y / N What Type? \_\_\_\_\_ How Long? \_\_\_\_\_

Do you have any other illnesses? Y / N What Type? \_\_\_\_\_ How Long? \_\_\_\_\_

Have you had any surgeries? Y / N What Type? \_\_\_\_\_ When? \_\_\_\_\_

When did you last have a medical check up? \_\_\_\_\_ When was your last eye exam? \_\_\_\_\_

**Medication-** Please answer all that apply.

Do you use any medications? Y / N Which ones and how often? \_\_\_\_\_

Do you use any over the counter medications? (aspirin, etc.) Y / N Which ones and how often? \_\_\_\_\_

Do you take vitamins? Y / N Which ones and how often? \_\_\_\_\_

What pharmacy do you usually use? \_\_\_\_\_

**Allergies-** Please answer all that apply.

Are you allergic to any medications? Y / N Which ones? \_\_\_\_\_ Reaction: \_\_\_\_\_

Do you have any other allergies? (seasonal, food, soaps, ect.) Y / N Which ones? \_\_\_\_\_

On your next visit please list any changes here: \_\_\_\_\_

On your next visit please list any changes here: \_\_\_\_\_

On your next visit please list any changes here: \_\_\_\_\_

**Family & Social History**

Does anyone in your family have diabetes or high blood pressure? Y / N Who? \_\_\_\_\_

Are there any other serious conditions that run in your family? Y / N What? \_\_\_\_\_

Has anyone in your family had any serious eye conditions such as cataracts, glaucoma, retinal problems, or lazy eye? Y / N

Who? \_\_\_\_\_ What? \_\_\_\_\_

Do you use tobacco products? Y / N Do you use alcohol? Y / N Do you use any recreational drugs? Y / N

**Please sign & date the following:**

I certify that the above information is accurate to the best of my knowledge.

I acknowledge that Hopkins Eye Clinic has offered me a copy of the HIPAA regulations.

I authorize Hopkins Eye Clinic to obtain any medical and vision records at my request.

I authorize Hopkins Eye Clinic to release my vision records at my request.

I authorize Hopkins Eye Clinic to submit a claim to my insurance company for services rendered.

I understand that my insurance company may want to review my records for quality control.

I agree to pay clinic fees if my insurance company does not cover the charges.

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reviewed by \_\_\_\_\_ and deemed accurate on Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reviewed by \_\_\_\_\_ and deemed accurate on Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reviewed by \_\_\_\_\_ and deemed accurate on Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*Please return this form to the front desk. Thank you, the doctor will be with you shortly.*