HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	☐ Yes ☐ No	☐ Yes ☐ No	Hepatitis (Type_____)	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	☐ Yes ☐ No	Lazy Eye	☐ Yes ☐ No	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	☐ Yes ☐ No	Lupus	☐ Yes ☐ No	☐ Yes ☐ No
Bleeding	☐ Yes ☐ No	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	Poor Color Vision	☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No	Retinal Disease	☐ Yes ☐ No	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	Shingles	☐ Yes ☐ No	☐ Yes ☐ No
Drug Sensitivity	☐ Yes ☐ No	☐ Yes ☐ No	Skin Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No	Thyroid Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Eye Surgery	☐ Yes ☐ No	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	Turned Eye	☐ Yes ☐ No	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	☐ Yes ☐ No	Are you pregnant? _____	Number of children_____	
Heart Condition	☐ Yes ☐ No	☐ Yes ☐ No	Tobacco use _____	Alcohol use_____	

MEDICATIONS

List any medications you are currently taking, including eye drops:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Relationship to Beneficiary

_____ for any services furnished to me by that provider.

Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Beneficiary, Guardian or Personal Representative — Date

_____ _____

Please print name of Beneficiary, Guardian or Personal Representative — Relationship to Beneficiary

PHONE NUMBERS

Home (_____) _____ Cell (_____) _____ Spouse's Work Phone (_____) _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship_____

Home (_____) _____ Cell (_____) _____ Work Phone (_____) _____ Ext _____