

# CARTHAGE EYE CLINIC

Please complete all areas below in print.

## PATIENT INFORMATION

FIRST MI LAST  
NAME \_\_\_\_\_ GENDER Male Female  
ETHNICITY (CHOOSE ONE) AFRICAN AMERICAN \_\_\_\_\_ HISPANIC \_\_\_\_\_ WHITE \_\_\_\_\_ OTHER \_\_\_\_\_  
STREET CITY, STATE, ZIP  
ADDRESS \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

## RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE

FIRST MI LAST  
NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
WORK PHONE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

## MEDICAL INSURANCE INFORMATION

MEDICARE # \_\_\_\_\_ MEDICAID # \_\_\_\_\_

OTHER INS. \_\_\_\_\_ *Please allow us to make a copy of your cards.*

**ACKNOWLEDGEMENT:** I understand payment is expected at the time service is rendered. If other arrangements are needed, I will discuss this with a member of the staff. I authorize any insurance company to pay benefits directly to the doctor. I also authorize the release of medical information necessary in handling my claims. I further authorize this office to release or obtain any required medical information to or from any medical facility.

\*\*\*Delinquent accounts are subject to interest of 1.5% per month plus collection fees.\*\*\*

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

over

## MEDICAL HISTORY

Your Medical Doctor: \_\_\_\_\_ Last Medical Exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Allergies to medicines: \_\_\_\_\_

Medications (include non-prescription): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

List all major injuries and surgeries: \_\_\_\_\_

\_\_\_\_\_

## SOCIAL HISTORY

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Do you use alcohol?     No             Rarely         Moderate     Daily

Do you smoke?         No             Rarely         Moderate     Daily

Do you use illegal drugs?     No             Yes    If yes, type / how long: \_\_\_\_\_

Have you ever been exposed to or infected with:     Hepatitis     HIV     Syphilis     Gonorrhea

## REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

	<u>Circle</u>			<u>Circle</u>	
<b>CONSTITUTIONAL</b>			<b>EAR, NOSE, MOUTH, THROAT</b>		
Fever, Weight Loss/ Gain	Y	N	Allergies/ Hay Fever	Y	N
<b>INTEGUMENTARY (SKIN)</b>	Y	N	Sinus Congestion	Y	N
<b>NEUROLOGICAL</b>			Runny Nose	Y	N
Headaches	Y	N	Chronic Cough	Y	N
Migraines	Y	N	Dry Throat/ Mouth	Y	N
Seizures	Y	N	<b>RESPIRATORY</b>		
Depression	Y	N	Asthma	Y	N
<b>VASCULAR/ CARDIOVASCULAR</b>			Chronic Bronchitis	Y	N
Diabetes	Y	N	Emphysema	Y	N
Cholesterol	Y	N	<b>GASTROINTESTINAL</b>		
Heart Trouble	Y	N	Diarrhea	Y	N
High Blood Pressure	Y	N	Constipation	Y	N
Vascular Disease	Y	N	<b>Genitourinary</b>		
<b>EYES</b>			Genitals/ Kidney/ Bladder	Y	N
Loss of Vision	Y	N	<b>BONES / JOINTS / MUSCLES</b>		
Blurred Vision	Y	N	Arthritis	Y	N
Loss of Side Vision	Y	N	Muscle Pain	Y	N
Double Vision	Y	N	Joint Pain	Y	N
Dryness	Y	N	<b>LYMPHATIC / HEMATOLOGIC</b>		
Redness	Y	N	Anemia	Y	N
Sandy or Gritty Feeling	Y	N	Bleeding Problems	Y	N
Itching	Y	N	Slow to Heal	Y	N
Burning	Y	N	Sickle Cell	Y	N
Foreign Body Sensation	Y	N	<b>ENDOCRINE</b>		
Excess Tearing/ Watering	Y	N	Thyroid/ Other Glands	Y	N
Glare/ Light Sensitivity	Y	N	Excessive Thirst/ Urination	Y	N
Eye Pain or Soreness	Y	N	<b>ALLERGIC / IMMUNOLOGIC</b>	Y	N
Sties or Chalazion	Y	N	<b>PSYCHIATRIC</b>	Y	N
Flashes/ Floaters in Vision	Y	N			

Doctor's Signature / Date \_\_\_\_\_