Medical History

(Please Print)

Patient's Name: _____ Age: _____ Sex: _____

Primary Care Physician: _____

1. Are you currently experiencing any eye symptoms? Please circle all that apply:

Eye Pain	Blurred Vision	Eyelid Crusting	Flashes of Light
Halos	Red Eyes	Light Sensitivity	Double Vision
Floaters	Discharge	Eye Pressure	Foreign Body Sensation

2. Please circle any of the following you would like more information about:

Laser Vision Correction	Cataract Surgery	Diabetic Eye Disease
Glaucoma	Macular Degeneration	Other: _____

3. Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)
   Yes ☐ No ☐ If YES, please explain: _____
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment, eye injury)
   Yes ☐ No ☐ If YES, please explain: _____
3. Have you ever had any eye surgery?
   Yes ☐ No ☐ If YES, please explain: _____
4. Have you ever been hospitalized?
   Yes ☐ No ☐ If YES, Please provide reason: _____
5. Do you take any medications?
   Yes ☐ No ☐ If YES, Please list: _____
6. Do you take any eye medications:
   Yes ☐ No ☐ If YES, Please list: _____
7. Do you have any drug or food allergies?
   Yes ☐ No ☐ If YES, Please list: _____

Review of Systems

Do you currently have any of the following problems:	YES	NO	If YES please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems)	☐	☐	_____
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea)	☐	☐	_____
Urinary problems (e.g., pain discomfort, blood in urine)	☐	☐	_____
Skin problems (e.g., rashes, excessive dryness)	☐	☐	_____
Musculloskeletal problems (e.g., muscle aches, joint pain)	☐	☐	_____
Neurological problems (e.g., numbess, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric problems (e.g., depression, anxiety)	☐	☐	_____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
Yes ☐ No ☐ If YES, please explain: _____

Do you smoke? If yes, how much? ____ Drink alcohol? If yes, how much? ____

_____

M.D. Signature Date

Consent to Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations & Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, John A. Stefano MD, PC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- ☐ A basis for planning my care and treatment
- ☐ A means of communication among the many health professionals who contribute to my care
- ☐ A source of information for applying my diagnosis and surgical information to my bill
- ☐ And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided the opportunity to view the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address that I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to see and obtain copies of my medical record, I understand that I have the right to request amendments be made to my medical record. I understand that a six-year history of all disclosures will be accessible to me including the purpose of the disclosure and the address of the recipient. I may receive a copy of this history within 60 days of my written request, and I understand that I may have to pay a reasonable charge of $0.20 per page for any copies after the first request in a 12-month period. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice as already taken action in reliance thereon.

My Authorization

You, John A. Stefano MD, may use or disclose the following health care information:

☐ ALL my health information maintained by you

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s) _____

☐ My appointment information and test results can be left on my answering machine

☐ NONE of my health information

You may use or disclose this health information to:

Spouse (name) _____ Siblings (names)_____

Children (names)_____ Other_____

_____ _____

_____ _____

Signature of Patient or Legal Representative **Date**