INTERIM MEDICAL HISTORY

Name__________________ Date of Birth______________ Date____________

List all prescription medications you currently take or provide a list **including dosage and frequency**:

List all over-the-counter medications and vitamins you take:

List all allergies to medications:

List all surgeries you have ever had:

Please answer the following questions:	SELF		(Family Member includes Father, Mother, Sibling, Grandparent or Child ONLY)	Family Member	
	YES	NO	Please describe any "YES" below:	YES	NO
high blood pressure/high cholesterol					
general/constitutional (fever, etc)					
ear, nose, throat					
cardiovascular, heart problems					
respiratory/breathing/TB					
gastrointestinal/stomach					
muscles/bones/joints					
skin					
neurological (nerve disorders)					
psychiatric					
endocrine (diabetes, thyroid, etc)					
Glaucoma/Macular Degeneration					
Cancer					

SOCIAL:

changes in employment?______________

marital status (married, divorced, single, widowed)______________

living arrangements (alone, with family member, nursing home, etc.)______________

do you drive? yes no if yes, do you have visual difficulty when driving? yes no

do you have problems with night vision? yes no

do you drink alcohol? yes no if yes: occasional 1/day 2-3/day 4+/day

do you smoke? yes no if yes: occasional ½ pack/day 1 pack/day 1+ pack/day

do you have a living will/advance directive? yes no *Information available at front desk.*

Have you recently been outside the US? yes no Location______________

Have you ever received hormones to increase your height? yes no

Have you ever received an organ or tissue transplant? yes no

Are you pregnant or is there any possibility you could be pregnant? yes no

Above history reviewed______________________ date____________

CAREY DOZIER MD/JAMES P. RICHMOND JR MD

EAST RIDGE EYE CENTER

TODAYS DATE:

PATIENT FULL NAME:	**DATE OF BIRTH:** **SOCIAL SECURITY NUMBER:**
BEST CONTACT PHONE # :	**MAILING ADDRESS:**
EMAIL ADDRESS: **PREFERRED LANGUAGE:**	**MARITAL STATUS:** ***SPOUSE NAME:*** ***SPOUSE PHONE NUMBER:***
RACE: ***THIS IS IMPORTANT AS SOME RACES ARE MORE AT RISK OF DEVELOPING CERTAIN EYE DISEASES.*** **IF PT IS A MINOR:** OTHER PARENT/GUARDIAN NAME: OTHER PARENT/GUARDIAN PHONE:	**RESPONSIBLE PARTY:** ***ADDRESS:*** ***PHONE:*** ***IS THIS PERSON THE PATIENT'S LEGAL REPRESENTATIVE? Y/N?*** ____

EMERGENCY CONTACT (*SOMEONE AT DIFFERENT ADDRESS*)

NAME:	**RELATIONSHIP:**
PHONE NUMBER:	**ADDRESS:**

EMPLOYER INFORMATION

PLEASE CIRCLE ONE: EMPLOYEED RETIRED DISABLED OTHER

NAME/COMPANY:	**PHONE NUMBER: ;**
ADDRESS :	DO WE HAVE PERMISSION TO VERIFY YOUR EMPLOYMENT?______________________ *IF YES PLEASE SIGN*

INSURANCE INFORMATION

PRIMARY INSURANCE:	**ID NUMBER:**
PHONE NUMBER:	**GROUP NUMBER:**
SUSCRIBER:	
SECONDARY INSURANCE:	**ID NUMBER:**
PHONE NUMBER:	**GROUP NUMBER:**

PRIMARY CARE PROVIDER/OTHER

IF A REFERRAL IS NOT ON FILE AND IS REQUIRED BY YOUR INSURANCE – YOU WILL NEED TO RESCHEDULE OR PAY FULL SERVICE AMOUNTS.

NAME/OFFICE:	**PHONE NUMBER:**
NAME/OFFICE:	**PHONE NUMBER:**

PHARMACY:

NAME:	**PHONE NUMBER:**
ADDRESS:	