Patient History Record

_____ (____)_____

Date (MM/DD/YY) Patient Name D.O.B. Phone Number

_____

Primary Care Physician Occupation Employer

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

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

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 (eg., hearing loss, sinus problems, sore throat)……..	[ ]……..	[ ]	_____
Heart Problems (eg., chest pains, irregular heart beat)……..	[ ]……..	[ ]	_____
Respiratory problems (eg., shortness of breath, wheezing, coughing)……..	[ ]……..	[ ]	_____
Urinary problems (eg., pain or discomfort, blood in urine)……..	[ ]……..	[ ]	_____
Skin problems (eg., rashes, excessive dryness)……..	[ ]……..	[ ]	_____
Musculoskeletal problems (eg., muscle aches, joint pain, swollen joints)……..	[ ]……..	[ ]	_____
Neurological problems (eg., numbness, weakness, headaches, paralysis)……..	[ ]……..	[ ]	_____
Psychiatric problems (eg., depression, anxiety)……..	[ ]……..	[ ]	_____
Gastrointestinal problems (eg., heartburn, abdominal pain, diarrhea, vomiting)...	[ ]……..	[ ]	_____

Do any medical or eye diseases run in your family (eg., 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? _____
If employed, how many hours per week do you work?_____

_____
M.D. Signature Date

Berkshire EyeCenter

Date(s) Reviewed:	MD Signature	Date(s) Reviewed:	MD Signature
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS

Patient's Name:_____

MEDICATION	DOSAGE	FREQUENCY

PATIENT REGISTRATION SHEET

Dr. Mr. Ms. Miss_____ Date: _____

Home Phone: _____Work Phone: _____ Mobile Phone: _____

Address: _____

Email Address: _____

Sex: M F Marital Status: Single Married Other

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Referred By: _____ Primary Care MD: _____

_____

In Case of Emergency Contact: (Name) _____ (Phone #) _____

_____

I give Berkshire Eye Center physicians and employees permission to discuss care with:

Name_____ Relationship_____ Phone # _____

Name_____ Relationship_____ Phone # _____

Patient Signature_____ Date _____

I give Berkshire Eye Center permission to leave messages on my Home, Mobile, or Work Phone:

Patient Signature: _____ Date: _____

Receipt of Privacy Notice: *I acknowledge receipt of the Berkshire Eye Center, P.C. Notice of Privacy Practices.*

Patient Signature: _____ Date: _____

Assignments of Benefits: *I authorize payment of medical benefits to Berkshire Eye Center, P. C. for services provided.*

Patient Signature: _____ Date: _____

Information Regarding Dilating Drops

Dilating drops are used to enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected.

Because driving may be difficult immediately after examination, it is best for you to make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from dilating drops. This is extremely rare and treatable with immediate medical attention.