RAMESH R. SHAH, M.D., F.A.C.S., F.I.C.S., P.C.
HEERAL R. SHAH, M.D.
EYE SURGEONS

MEDICAL HISTORY FORM

Patient Name:____

INSTRUCTIONS: Please check (X) all answers applicable to you and fill in the blank(s) as needed:

EYE COMPLAINTS/PROBLEMS:

____Right Eye ____Left Eye ____Both Eyes

____Red ____Pain ____Mattering
____Itching ____Watering ____Scratchy
____Blurred Vision ____Flashing Lights ____Sudden Loss of Vision
____Spots in Vision
Other:____
____

How long have you had the above problems?______________________________

DO YOU HAVE DIFFICULTY PERFORMING ANY OF THE FOLLOWING ACTIVITIES DUE TO YOUR DECREASED VISION?

____Driving ____Watching TV
____Seeing street signs/lights ____Reading words on TV
____Judging distance when driving ____Seeing faces on TV
____Driving at night ____Reading weather warnings on TV
____Sensitive to light when driving

____Reading
____Words run together
____Words blur after reading awhile
____Not able to read at all

Other Vision Problems:
____Making out peoples faces
____Having trouble walking
____

List any other problems you may be having due to your vision:______________________________
____

EYE HISTORY: Prior Eye Surgery______________________________
Ocular Medications______________________________
____

FAMILY MEDICAL HISTORY: Has any family member had?

____Cancer ____Diabetes ____Heart Trouble
____High Blood Pressure ____Cataract ____Glaucoma
____Retinal Detachment

Please list any other major health problems your family members have had:__________________
____

PRESENT MEDICAL HISTORY:

Please list all medications that you are ALLERGIC to:________________________________
____
____

Do you have or have you had in the past any of the illnesses listed below:

____Heart Trouble	____High Blood Pressure	____Diabetes
____Emphysema	____High Cholesterol	____Thyroid
____Asthma	____Migraine Headaches	____Cancer
____AIDS	____Tuberculosis	____Cataract
____Glaucoma	____Hepatitis	____Epilepsy
____Stroke	____Arthritis	

Please list any other medical illnesses:________________________________
____
____

Please list all medications you are now taking:________________________________
____
____

Please list any surgery you have had in the past:________________________________
____
____

SOCIAL HISTORY:

Are you:	Do you:	Do you:
____Married	___Live alone	Smoke _____Yes _____No
____Single	___Live with spouse	How much:________________
____Widow	___Live with relative	If no, when did you quit:
____Widower	___Live with friend	________________________
	___Live in nursing home	

Do you:
Take alcohol _____Yes ____No If yes, how much and how often:__________________

If you should happen to require surgery, do you have someone to help you following surgery if needed? ______Yes _____No Who:______________________________

PATIENTS UNDER 16 ONLY

_____Normal birth _____C-Section Birth Weight_____lbs____oz
Pre-mature birth ____Yes ____No If yes, how much pre-mature:____________________
Has the child had normal growth/development since birth? _____Yes _____No
If no, please explain:____
____

PATIENT INFORMATION:

NAME: ____
FIRST M.I. LAST PREFERRED NAME

MAILING ADDRESS: ____
STREET CITY STATE ZIP

PRIMARY PHONE #: ____________________ SECOND PHONE #: ____________________

BIRTHDATE: __________ SEX: M F PREFERRED LANGUAGE: __________ RACE: __________

EMAIL ADDRESS: ____________________ SOCIAL SECURITY #: ____________________

EMPLOYER NAME: ____________________ EMPLOYER PHONE#: ____________________

MARITAL STATUS: ____________________ NAME OF SPOUSE IF MARRIED: ____________________

EMERGENCY CONTACT: ____________________ EMERGENCY PHONE #: ____________________

HOW DID YOU HEAR ABOUT OUR PRACTICE? YELLOW PAGES DR. REFERRAL FRIEND/RELATIVE OTHER

REFERRING PHYSICIAN: ____________________ FAMILY PHYSICIAN: ____________________

INSURANCE INFORMATION:

PRIMARY INSURANCE NAME: ____

POLICY #: ____

MEMBER NAME: ____________________ DATE OF BIRTH: ____________________

EMPLOYER: ____________________ SOCIAL SECURITY #: ____________________

RELATIONSHIP TO ,MEMBER: ____________________ PHONE #: ____________________

SECONDARY INSURANCE NAME: ____

POLICY #: ____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I request payment of authorized Medicare/Other insurance benefits be made either to me or on my behalf to Ramesh R. Shah, M.D. for any service furnished to me by that physician. I authorize the release of any medical information about me needed to determine these benefits payable for related services to Health Care Financing Administration and its agents. I hereby understand I am financially responsible for any balance not covered by my insurance carrier. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. THANK YOU

SIGNATURE: ____ DATE: ____________________