

BOLING VISION CENTER

Patients Personal History

Date: _____

Patient Last Name _____ First _____ M.I. _____ Date of Birth _____

Patient's Address _____ City _____ State _____ Zip _____

Home Ph. _____ Cell Ph. _____ Work Ph. _____

Email Address _____

Age _____ Ht. _____ Wt. _____ Sex: M F Marital Status: S M W D or Separated Soc. Sec # _____

Referring Physician _____ Family Doctor _____

Responsible Party _____ Soc. Sec. # _____

Responsible Party Address _____ State _____ Zip _____ Home Ph. _____ Work Ph. _____

Employer Name _____ Employer Address _____

Employer Ph. _____

Relative to notify in case of Emergency _____ Phone _____

DO YOU HAVE OR HAVE YOU HAD: (Check yes or no box, give date diagnosed)

	YES	NO	DATE		YES	NO	DATE		YES	NO	DATE
Aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Rheumatic Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	High Fever after surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
				HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Have any of your living circumstances changed? If so, describe and give date of change (ie decreased or stopped smoking)

No Yes Do you regularly smoke? How much? _____ How many years? _____
 No Yes Do you regularly drink alcohol or beer? How much? _____
 No Yes Do you live alone? _____

PLEASE LIST ALL MEDICATIONS CURRENTLY TAKING INCLUDING ASPIRIN, VITAMINS, ETC. INCLUDE DOSAGE AND FREQUENCY:

DO YOU KNOW OF ANY BLOOD RELATIVE WHO HAS OR HAD: (CHECK AND GIVE RELATIONSHIP AND DATE)

Check yes or no box, give relationship and date diagnosed

	Yes	No	Relationship	Date		Yes	No	Relationship	Date
Age Related Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	High Fever after surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	Rheumatic Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

REVERSE SIDE ALSO PLEASE

Write in the names and years of any operations which you have had: _____

Name any drugs to which you are allergic: _____

Serious illnesses which you have had and year of occurrence: _____

Serious injuries or accidents and year of occurrence: _____

We are asking the following questions because hormonal changes can affect your vision.

WOMEN ONLY

No Yes Are you pregnant?
No Yes Are you now on or have ever taken the birth control pill? When? _____
No Yes Are you taking hormone supplements?

Please notify receptionist of any insurance changes.

This Medical history has been reviewed

Date	Patients Initials	Doctors Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature On File

I request that payment of authorized insurance benefits be made to me or on my behalf to Dr. Boling for any service furnished me by Dr. Boling or his employees. I authorize any holder of medical information about me to release to the insurance company or its agents, any information needed to determine benefits.

Date _____ Signature _____