NAME____ **DOB:** ________________

FAMILY History (Blood Relative Only)

Has anyone in your FAMILY ever had (Circle): **Cataracts** / **Macular Degeneration** / **Glaucoma** / **Eye Surgery**
Other Eye Problems, please specify:____

Has anyone in your FAMILY been treated for: **Diabetes** / **Hypertension** Relationship_____________________

PERSONAL Eye History
Are YOU having any of the following eye concerns (circle): **Redness / Burning / Itching / Tearing / Discharge / Dryness**
Have YOU had any of the following (circle): **Cataracts** / **Macular Degeneration** / **Glaucoma / Eye Surgery**
Retinal Detachment / **Floaters or Flashes**

Other Eye Problems: ____

Constitution			**Cardiovascular**			**Musculoskeletal**		
Fatigue Syndrome	Yes		Congestive Heart Failure	Yes		Arthritis	Yes	
Cancer	Yes		Heart Disease	Yes		Ankylosing Spondylitis	Yes	
Developmental Disabilities	Yes		Stroke/CVA	Yes		Fibromyalgia	Yes	
Other	Yes		Hypertension/High B.P.	Yes		Gout	Yes	
ENT			Other	Yes		Osteoporosis	Yes	
Laryngitis	Yes		**Psychiatric**			Muscular Dystrophy	Yes	
Hearing Loss	Yes		Depression	Yes		Osteoarthritis	Yes	
Dry Mouth	Yes		Anxiety Disorder	Yes		Other	Yes	
Sinusitis	Yes		Bipolar Disorder	Yes		**Integumentary/Skin**		
Other	Yes		Attention Deficit	Yes		Cold Sores	Yes	
Neurological			Other	Yes		Eczema	Yes	
Epilepsy	Yes		**Gastrointestinal**			Psoriasis	Yes	
Tumor	Yes		Celiac Disease	Yes		Rosacea	Yes	
Cerebral Palsy	Yes		Ulcer	Yes		Shingles	Yes	
Migraine	Yes		Colitis	Yes		Other	Yes	
Multiple Sclerosis	Yes		Acid Reflux	Yes		**Endocrine**		
Stroke/CVA	Yes		Crohn's Disease	Yes		Diabetes Type 1	Yes	
Other	Yes		Other	Yes		Diabetes Type II	Yes	
Respiratory			**Genitourinary**			**Hormone**	Yes	
Asthma	Yes		Pregnant	Yes		Thyroid Dysfunction	Yes	
Emphysema	Yes		Nursing	Yes		Other	Yes	
Smoker	Yes		Kidney Disease	Yes		Hematologic/Lymphatic		
Chronic Obstruction	Yes		Prostate Disease/Cancer	Yes		Anemia	Yes	
Bronchitis	Yes		Benign Prostate Hypertrophy	Yes		Large-Volume Blood Loss	Yes	
Sleep Apnea	Yes		STD	Yes		High Cholesterol	Yes	
Other	Yes		Other	Yes		Ulcer	Yes	
PLEASE LIST ALL CURRENT MEDICATIONS AND DOSAGES						Other	Yes	
						Allergy/Immunologic		
						Sjogren's Syndrome	Yes	
						Rheumatoid Arthritis	Yes	
						Lupus	Yes	
						Drug Allergies	Yes	
						Environmental Allergies	Yes	
						Other	Yes	

Do you use any of the following products?

Tobacco	**Yes**	**No**	**Amount** _______________________
Alcohol	**Yes**	**No**	**Amount** ________________________
Recreational Drugs	**Yes**	**No**	

SIGNATURE ____________________________________ DATE__________________

In order to comply with **HIPAA**'s Private Rule, it is the policy of this office to provide copies of our Notice of Privacy Practices (NPP) to every patient at their first appointment after April 14, 2003. Copies of our NPP are in the reception area. I acknowledge that I have received a copy of Drs. Boltz, Rengert, Delmore, and Delmore's Notice of Private Practices.

______________________________ ____ _______________

Patient Printed Name **Patient Signature (or guardian if under 18)** **Date**

We welcome **insurance** and third party payment plans. However, if your insurance denies payment you will be responsible for any balance unpaid by your insurance company.
<u>I agree to pay any balance not paid by my insurance of third party plan.</u>

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Insured Signature **Date** ______________________