East Bay Retina Consultants, *Inc.*

EBRC

PATIENT INFORMATION: Date: ______________

Name: Last	First	Middle	Marital Status M S D W

Address	Apt. No.	City	State	Zip

Home Telephone	Work Telephone	Cell Phone	Preferred: Home Wk Cell

Age	Birth Date	Sex	Email Address

Social Security Number	Preferred Language	Race/Ethnicity (goverment req.) ❑ Decline to state

Occupation	Employer (name & telephone)	Is this a workman's compensation claim? ❑ Yes ❑ No

Referring Doctor (name & city)	Primary Care Physician (name & city)

Emergency Contact Person (name & telephone)	Relationship

PRIMARY INSURANCE:

Company Name	I.D. Number	Group Number

SECONDARY INSURANCE:

Company Name	I.D. Number	Group Number

POLICYHOLDER INFORMATION: (Complete only if patient is NOT the policyholder)

Name: Last	First	Middle	Social Security Number

Address	Apt. No.	City	State	Zip

Home Telephone	Work Telephone	Cell Phone

Birth Date	Sex	Employer	How is patient related to policy holder?

WHICH PHARMACY DO YOU USE?

Name	Address	City

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Diseases and Surgery of the Retina, Vitreous & Macula

eastbayretina.com

Daniel A. Brinton, MD
Scott S. Lee, MD
Eugene S. Lit, MD
Soraya Rofagha, MD
Jesse J. Jung, MD

MEDICAL HISTORY FORM

Name: *Last*	*First*	*Middle*	**Date:**

I. EYE DISORDERS:

Please describe your current eye problem and symptoms that bring you here:
How long has it been going on? How severe is it?

Please mark any of the following which are problems for your eyes: NONE ☐

Eye symptom:	Eye symptom:
☐ Blurred vision	☐ Itching or burning
☐ Distorted vision	☐ Excess tearing
☐ Loss of side vision	☐ Glare
☐ Double vision	☐ Sensitivity to light
☐ Dry, gritty eyes	☐ Pain or soreness
☐ Redness, discharge	☐ Tired eyes

Describe:

List any eye medications you use:
(which eye?; how often?; what %?) NONE ☐

Do you drive? YES ☐ ; NO ☐
If not, why not? Vision ☐ ; Other ☐

Have you ever had any of the following conditions?

Eye disease:	YES	NO	When diagnosed?
Cataract	☐	☐	
Glaucoma	☐	☐	
Macular degeneration	☐	☐	
Retinal detachment	☐	☐	
Diabetic retinopathy	☐	☐	
Eye injury	☐	☐	
Other: ____________			

Describe:

List any eye surgery you have had:
(type of surgery?; year?; which eye?) NONE ☐

List any blood relatives, living or dead, with eye disease: NONE ☐

Other comments about your eyes:

➧ PLEASE COMPLETE OTHER SIDE ALSO

II. OTHER HEALTH PROBLEMS:

Have you had any problems with the following?

	YES	NO	What & when?
Skin	❑	❑	
Head or neck	❑	❑	
Ear, nose, mouth, throat	❑	❑	
Stomach, bowels, digestion	❑	❑	
Lungs, breathing, asthma	❑	❑	
Heart, blood vessels	❑	❑	
Kidneys, dialysis, genitals	❑	❑	
Bones, joints, muscles	❑	❑	
Nervous system	❑	❑	
Psychiatric, depression	❑	❑	
Blood, lymph, sickle cell	❑	❑	
Allergies, immunity	❑	❑	
Hormones, thyroid	❑	❑	
Fevers, energy, weight	❑	❑	
Migraines	❑	❑	

Describe:

Have you ever been diagnosed with any of the following conditions?

Diagnosis:	YES	NO	What kind & when?
Diabetes	❑	❑	
Heart disease	❑	❑	
Stroke	❑	❑	
Cancer	❑	❑	
Arthritis	❑	❑	
Injuries	❑	❑	
AIDS / HIV	❑	❑	
High blood pressure	❑	❑	

Other:____________________

Describe:

Please list any medications to which you are allergic or sensitive: NONE ❑

List any medications you take besides eye drops: *(dose?; how often?)* NONE ❑

Are you on aspirin? ❑; coumadin? ❑; neither ❑

What surgical procedures have you had besides eye surgery? *(when?)* NONE ❑

List blood relatives, living or dead, with other serious diseases: NONE ❑

Do you smoke? YES ❑ ; NO ❑

*For how many years:*________ QUIT ❑

*How many packs per day:*______

Do you drink more than one alcoholic beverage per day? YES ❑ ; NO ❑

*If yes, how many per day on average:*________

Other comments about your health:

THANK YOU!

History reviewed by physician: *Date*

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PATIENT'S PRIVACY RIGHTS

Your rights under the federal Health Insurance Portability and Accountability Act (HIPAA) include:

1. The right to receive the Notice of Privacy Practices: This informs you of your rights and how to exercise them. The Notice of Privacy Practices is on public display and a copy is available to you in our office upon request.

2. The right of Access: You may request inspection of your medical record and may request copies. There is a fee to produce the copies. The process to follow and how to request copies is explained in the Notice of Privacy Practices.

3. The right to Request an Amendment or Addendum: The Notice of Privacy Practices describes how to file a request for an amendment or addendum to your medical record.

4. The right to an Accounting of Disclosures: We can be asked to account for certain disclosures of your protected health information other than those you requested. The Notice of Privacy Practices describes how to request an accounting.

5. The right to Request Restrictions: You have the right to request restrictions on how we will communicate with you, or your family, or how we will release information.

6. The right to Complain: You have the right to complain if you think that your privacy rights have been violated. The Notice of Privacy Practices describes where to file a complaint, either within or outside of East Bay Retina Consultants, Inc.

PLEASE NOTE:

We routinely send our post card reminders for your eye appointment and/or tests by mail to the home address you provide, or leave messages on answering machines on phone numbers you provide. In addition, we may discuss your medical condition with those who identify themselves as your immediate family (parents, siblings, children or spouse), other close relatives, and significant others, unless you have specifically asked us not to. We may also leave medical information on answering machines or send it to you by mail, fax, email, or other means. If you wish to have any information which we routinely disclose in this manner to be withheld, please mention it to your physician, or any of our staff. You will be asked to sign a form.

I have read and I understand the above information.

____________________________ Patient's Signature

__________________ Date

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