5729 Esplanade Dr, Corpus Christi, TX 78414
Phone: (361) 991-3800 Fax: (361) 991-6510

Medical History Form

Date of Exam : ________________________

Patient Name: ____ Date of Birth: __________________________ Male / Female

Family Doctor: _______________________________ Last Exam: ______________________ By Dr. : _____________________________

EYE HISTORY:

Previous eye diagnoses: ____

Previous eye surgery? YES / NO Describe:____

Previous eye injury? YES / NO Describe: ____

Do you wear glasses? YES / NO Contact Lens? YES / NO

PERTINENT MEDICAL HISTORY:

List all important medical history or problems you have had: ____

____

____

Have you had any surgeries? YES / NO If yes please explain: ____

____

MEDICATIONS:

Please list all medication allergies: ____

List **eye** drops/ medications:

____
____
____
____
____

List all other Medications:

____
____
____
____
____

FAMILY HISTORY:

Do any of your **blood relatives** have:

Glaucoma?	____YES	____NO	Diabetes?	____YES	____NO
Macular Degeneration?	____YES	____NO	High Blood Pressure	____YES	____NO
Retinal Detachment?	____YES	____NO	High Cholesterol?	____YES	____NO
Blindness?	____YES	____NO	Thyroid Disease?	____YES	____NO
Arthritis?	____YES	____NO	Other?______________________________		

REVIEW OF SYSTEMS

CONSTITUTIONAL

Fever _____YES _____NO
Weight Loss _____YES _____NO

EYES

Blurred Vision _____YES _____NO
Loss of Vision _____YES _____NO
Fluctuating Vision _____YES _____NO
Loss of Side Vision _____YES _____NO
Double Vision _____YES _____NO
See Halos _____YES _____NO
Dryness _____YES _____NO
Excess tearing, watering _____YES _____NO
Mattering _____YES _____NO
Redness _____YES _____NO
Itching, burning _____YES _____NO
Glare / light sensitivity _____YES _____NO
Eye pain _____YES _____NO
Eyes feel tired _____YES _____NO
Irritated eye _____YES _____NO
Problems with night vision _____YES _____NO

EARS/ NOSE/ MOUTH/ THROAT

Sinus congestion _____YES _____NO
Runny nose/ postnasal drip _____YES _____NO
Dry mouth/ throat _____YES _____NO

CARDIOVASCULAR/ HEART

Chest pain _____YES _____NO
Irregular heart beat _____YES _____NO

RESPIRATORY/ LUNGS

Shortness of breath _____YES _____NO
Cough _____YES _____NO
Asthma _____YES _____NO

GASTROINTESTINAL

Stomach problems/ ulcers _____YES _____NO

GENITOURINARY

Kidney/ bladder problems _____YES _____NO
Dialysis _____YES _____NO

HEMATOLOGIC/LYMPHATIC

Anemia _____YES _____NO
Bleeding _____YES _____NO
Swollen Lymph Nodes _____YES _____NO

MUSCULOSKELETAL

Joint pain, arthritis _____YES _____NO
Weakness _____YES _____NO

SKIN

Skin Disease / breast disease _____YES _____NO

NEUROLOGIC

Seizures _____YES _____NO
Nerve disorders _____YES _____NO

PSYCHIATRIC

Anxiety _____YES _____NO

ENDOCRINE

Glandular disorders _____YES _____NO

ALLERGIC/ IMMUNOLOGIC

Chronic allergies _____YES _____NO
HIV +/ AIDS _____YES _____NO

SOCIAL HISTORY

Do you smoke? _____YES _____NO
Do you drink? _____YES _____NO
Do you use drugs? _____YES _____NO
Are you pregnant? _____YES _____NO

Any other additional information? _______________________
____
____
____
____
____
____
____
____
____

____ ____

Patient/ Responsible Party Signature Date

Ravi Krishnan, M.D., P.A.

First Name		Middle Name		Last Name
Address		**City and State**		**Zip Code**
Cell Phone ( )	**Home/Alternate Phone** ( )		**DOB**	**Race**
Ethnicity	**Sex** [ ] M [ ]F	**Social Security Number**	**E-mail Address**	
Emergency Contact Name		**Phone** ( )		**Relationship**

GUARANTOR INFORMATION Complete this section only if the patient is **NOT** responsible for this account.

Name	Relationship	DOB:	Sex [ ]M [ ]F
Address	**City, State, Zip**	**Contact Phone** ( )	
Employer	**Employer Address**	**Employer Phone**	

Referring Physician or Last Physician Seen:

PHARMACY	Address:	Phone:
1. PRIMARY INSURANCE NAME:	**Identification Number**	**Group Number**
Name Of Policy Holder	**Date Of Birth**	**Relationship To Policy Holder**
2. SECONDAY INSURANCE NAME:	**Identification Number**	**Group Number**
Name Of Policy Holder	**Date Of Birth**	**Relationship To Policy Holder**

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for any services furnished me, authorize any holder of medical information about me or my dependent to release to the to the insurance company any information needed to determine these benefits payable for related services. A photocopy of the assignment is to be considered as valid as the original until revoked. I understand that I am financially responsible for all charges whether or not covered by said insurance. I authorize Ravi Krishnan M.D., P.A. and The Eye Institute of Corpus Christ to treat my condition.

Patient Signature: ______________________________ **Date**______________

Ravi Krishnan, M.D., P.A.

Financial Arrangements

We are committed to providing you with the best possible care. We are here to help you.

- **If you have medical insurance, we will file a claim with your insurance company as a courtesy. In agreement with your insurance the provider is required to collect co-payment, deductible, or co-insurance at the time of service. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. We realize temporary financial problems may affect payment of your account. If such problems arise you will need to make payment arrangements with the billing department.**
- **Returned checks and overdue balances are subject to additional fees.**
- **Your insurance is a contract between you, your employer, and the insurance company. Our fees fall within the acceptable range by most insurances, and therefore are covered up to the maximum allowance determined by each carrier. Not all services are covered by your insurance. The individual requirements of your plan are your responsibility to comply with. If your plan requires that we use certain lab facilities or hospitals, or requires referrals or pre-certification or hospital admissions, you must remind us each time this is needed. We will make every effort to help you but we do not take responsibility for all of the requirements of the many plans.**

Authorization For Release of Protected Health Information

Release my protected health information to the following person(s)
Pertains to relatives or anybody that would be calling concerning your health information.

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

If you have special instructions on how your health information should be released please list specifications here:

____

____

I understand that I have the right to revoke this authorization, in writing, at any time.

Notice of Privacy Practices

Upon request I may receive a copy of The Eye Institute of Corpus Christi's Medical Notice of Privacy Practices, which is a statement that explains how my medical information will be used and disclosed.

Patient Name: ____________________________________ **DOB:** ____________________

Signature: _______________________________________ **Date:** ____________________

Authorized representative must submit copies of legal documentation supporting authority to act on the patient's behalf.