5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members
AIDS/HIV	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	☐ Yes ☐ No
Bleeding	☐ Yes ☐ No	☐ Yes ☐ No
Blindness	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
Drug Sensitivity	☐ Yes ☐ No	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No
Eye Surgery	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	☐ Yes ☐ No
Heart Condition	☐ Yes ☐ No	☐ Yes ☐ No
Hepatitis (Type_____)	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No
Lazy Eye	☐ Yes ☐ No	☐ Yes ☐ No
Lupus	☐ Yes ☐ No	☐ Yes ☐ No
Migraine Headaches	☐ Yes ☐ No	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	☐ Yes ☐ No
Poor Color Vision	☐ Yes ☐ No	☐ Yes ☐ No
Retinal Disease	☐ Yes ☐ No	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	☐ Yes ☐ No
Shingles	☐ Yes ☐ No	☐ Yes ☐ No
Skin Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	☐ Yes ☐ No
Thyroid Conditions	☐ Yes ☐ No	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No
Turned Eye	☐ Yes ☐ No	☐ Yes ☐ No
Are you pregnant? _____	Number of children_____	
Tobacco use _____	Alcohol use_____	

MEDICATIONS

List any medications you are currently taking, including eye drops:

_____

_____

Pharmacy Name_____

Phone (_____)_____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

6 MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____ for any services furnished to me by that provider.
Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary