Professional EyeCare Associates
Dr. Niemeier, Dr. Moore, Dr. Hussmann

PATIENT HEALTH HISTORY FORM

Last Name:	First Name:	Middle Initial:	Date of Birth:
Height: Weight:	Smoker: Y or N	Language: English or Specify Other _______________	

Race: *(Circle One)* African-American American-Indian Asian Native-Hawaiian Caucasian Other

Employment: *(Circle One)* Retired Employed Full-Time Student Part-Time Student Other

Marital Status: *(Circle One)* Single Married Divorced Widowed Other

Primary Care Physician: **Last Eye Exam:** **Blood Pressure:**

Glaucoma	Y	N	Diabetes	Y	N	Macular Degeneration	Y	N
Cataract	Y	N	Hypertension	Y	N	Other:_______________________________________		

Glaucoma	Y	N	Heart Disease	Y	N
Cataract	Y	N	Stroke	Y	N
Macular Degeneration	Y	N	Vascular Disease	Y	N
Diabetes	Y	N			
Hypertension	Y	N	Multiple Sclerosis	Y	N
			Epilepsy	Y	N
Drug Allergy	Y	N	Alzheimer's	Y	N
Environmental Allergy	Y	N	Parkinson's	Y	N
Rheumatoid Arthritis	Y	N	Cerebrovascular	Y	N
Lupus	Y	N			
			STD/STI	Y	N
Fibromyalgia	Y	N	Viral Herpetic	Y	N
Muscular Dystrophy	Y	N	Chlyamydia	Y	N
Osteoarthritis	Y	N			
Ankylosing Spondylitis	Y	N	Anemia	Y	N
			Large Volume Blood Loss	Y	N
Crohn's	Y	N	Leukemia	Y	N
Colitis	Y	N	Asthma	Y	N
Ulcer	Y	N	Bronchitis	Y	N
Digestive	Y	N	Emphysema	Y	N
Developmental Disability	Y	N	Non-Insulin Dependent Diabetes	Y	N
Weight Loss	Y	N	Insulin Dependent Diabetes	Y	N
Fever	Y	N	Thyroid Dysfunction	Y	N
Fatigue	Y	N	Hormonal Dysfunction	Y	N
Trauma	Y	N			
Depression	Y	N			
Panic Disorder	Y	N			
Schizophrenia	Y	N			
Inflammatory Disorders	Y	N			
Blurred Vision	Y	N			
Double Vision	Y	N			
Eczema	Y	N			
Rosacea	Y	N			
Psoriasis	Y	N			

List Surgeries:
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List Medications:
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List Medicine Allergies:
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PLEASE READ CAREFULLY & SIGN: I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I understand that if any unpaid balance is assigned to a collection agency or attorney, I will be responsible for a collection fee of 33.3% added to my account. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this on all insurance submissions. I have also been notified of the Notice of Privacy Practices from Professional Eyecare Associates.

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Responsible Party **Date**