MEDICAL, PERSONAL, AND FAMILY HISTORY

Please check any/all that apply:

	Self	Relative
Glaucoma	_____	_____
Cataracts	_____	_____
Diabetes	_____	_____
Retinal Disease	_____	_____
High Blood Pressure	_____	_____
Macular Degeneration	_____	_____

	Self	Relative
Thyroid Problems	_____	_____
Asthma	_____	_____
Heart Disease	_____	_____
Lung Disease	_____	_____
Eye Disease	_____	_____
Eye Surgery	_____	

	Self
Dryness or pain in eyes	_____
Blurred Vision	_____
Frequent Headaches	_____
Double Vision	_____
Eye Infection	_____
Elevated Cholesterol	_____

Are you being treated for any additional medical conditions? ☐Yes ☐No If yes, what:_______________

List all medications you are taking: _______________

List any medications you are allergic to: _______________

Do you experience the following?

Floaters ☐Yes ☐No Any new? ☐Yes ☐No Any worse lately? ☐Yes ☐No

Flashes ☐Yes ☐ No Any new? ☐Yes ☐No Any worse lately? ☐Yes ☐No

Migraine Headaches ☐Yes ☐No How often? _______________

Have you had any?

Head Injuries ☐Yes ☐ No If yes, when: _______________

Eye Injuries ☐Yes ☐ No If yes, when: _______________

REVIEW OF SYSTEMS

Please CIRCLE conditions that apply--Do you currently, or have you ever had any problems in the following areas:

General	Chronic fever, weight loss/gain, fatigue
Cardiovascular	Chest pain, heart surgery, irregular heartbeat, **high blood pressure**
Ears, Nose, Throat, Mouth	Hearing loss, sinus, sore throat
Respiratory	Shortness of breath, asthma, bronchitis, emphysema, COPD
Gastrointestinal	Heartburn, vomiting, abdominal pain
Genitourinary	Kidney, bladder/urinary, genital
Musculoskeletal	Arthritis, muscle pain, joint pain, head or neck injury
Integumentary/Skin	Growths, rashes, acne, excessive dryness
Neurological	Headaches, migraines, seizures, numbness
Psychiatric	Depression, anxiety, Insomnia
Endocrine	**Diabetes**, thyroid, problems with other glands
Hematologic/Lymphatic	Anemia, cholesterol, bleeding problems
Allergic/Immunologic	Seasonal Allergies, Rheumatoid, AIDS, Allergy Shots, Lupus

Other conditions_______________

With my signature, I authorize treatment by Dr Julius N. Skeete & Associates, P.C. I understand I am financially responsible for all charges and any services rendered including, if applicable, the balance remaining after possible insurance benefits. I authorize Dr Julius N. Skeete & Associates, P.C to act on my behalf regarding services received in their offices. I authorize the release of any medical information necessary to process my insurance claim. I assign and request that insurance payments be made directly to Dr Julius N. Skeete & Associates, P.C This office is HIPAA compliant. A copy of the Privacy Information is available at request. I understand that certain services may not be covered by my insurance company and I will be responsible for the out of pocket expenses. It is my responsibility to contact my insurance company to make Dr Julius N. Skeete & Associates, P.C is a participating provider.

Signature_______________ Date_______________