MICHAEL G LIM , MD
Medical History

Patient: _____ _____ _____
Date of Birth Todays Date

*Reason for Appt: _____

*Medications:

_____

_____

_____

*Drug Allergies and Reactions: _____

Do you have or ever had:

yes	no	High Blood Pressure
yes	no	Sinus
yes	no	Dry Mouth/Throat
yes	no	Asthma
yes	no	Cough
yes	no	Change in Bowel Habits
yes	no	Heartburn
yes	no	High Urinary Output
yes	no	Arthritis
yes	no	Joint Pain
yes	no	Rash
yes	no	Migraines
yes	no	Stroke
yes	no	Depression
yes	no	Diabetes
yes	no	Thyroid
yes	no	Blood Clotting Abnormality
yes	no	Allergic Disorder
yes	no	Chicken Pox
yes	no	Co-Vid 19/Coronavirus
If Yes		Date _____
yes	no	Unable to lay flat on back
If Yes		Due to what condition?

_____

Any other Medical Conditions

_____

Social History

yes	no	Tobacco Use
yes	no	Alcohol Use

Eye Conditions/Surgeries

Which eye		
L	R	Cataract
L	R	Cataract Surgery
	Dates	_____
	Surgeon	_____
L	R	Corneal Transplant
L	R	Glaucoma
L	R	Glaucoma Surgery
	Dates	_____
	Surgeon	_____
L	R	LASIK
	Dates	_____
	Surgeon	_____
L	R	Macular Degeneration
L	R	PRK
L	R	Pterygium Surgery
L	R	Retinal Detachment
L	R	RK
L	R	Vitrectomy
L	R	Injuries

Family History

			Which Relative
yes	no	Cataract	_____
yes	no	Glaucoma	_____
yes	no	Macular Degeneration	_____
yes	no	Colorblindness	_____
yes	no	Cancer	_____
yes	no	Diabetes	_____
yes	no	Heart Disease	_____
yes	no	Deafness	_____

Michael G Lim, MD ~ Board Certified Ophthalmologist~2402 W Pierce Ste 1B~Carlsbad, NM 88220~Ph. 575-887-5325

THIS OFFICE COMPLIES WITH THE GOVERNMENT 5010 COLLECTION OF HEALTHCARE DATA.
ADDITIONAL REQUIRED INFORMATION IS INDICATED BY (*)

Last Name	First Name	MI	Suffix	M F Gender	Date of Birth

MAILING ADDRESS

Street/PO Box _____

City _____ **State** _____ **Zip** _____

***Type** *(circle)* Home Apartment Business Other _____

Home Ph _____ **Work Ph** _____ **Cell Ph** _____

***Email** _____

***Preference for communication** (*circle*): Mail Home Ph Work Ph Cell Ph Email

Social Security _____

***Primary language** *(circle)* English Spanish French Chinese German Other _____

***Race** *(circle)* American Indian, Alaskan Native, African American, Black, Native Hawaiian, Pacific Islander, White, Decline to State, Other _____

***Ethnicity** *(circle)* Non-Hispanic Hispanic Decline to State

INSURANCE INFORMATION	**Primary Insurance**	**Secondary Insurance**
Name of Insurance		
Policy Holder Name		
Policy Holder SS#		
Policy Holder DOB		
Relationship to Patient	Self Spouse Son/Daughter Other	

PRIMARY CARE DOCTOR _____ **Phone** _____

IS THIS WORKER'S COMPENSATION? YES NO **IS PATIENT A MINOR?** YES NO

THIS OFFICE FOLLOWS HIPPA GUIDELINES. WOULD YOU LIKE TO READ A COPY? YES NO

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____

My signature confirms that I give consent to treat for the person identified above. I understand that this office files insurance claims as a courtesy to patients. I authorize the release of any medical and/or insurance information needed to process all claims and authorize that payments directed to Michael G. Lim, MD. In cases of ANY insurance dispute, if no insurance is indicated, or if any other third-payor declines to pay, I will take personal responsibility for any unpaid amounts.

Signature _____ *Date* _____