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Patient Medical History Questionnaire

Dr. Andrew Clarke & Associates

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Patient Name________________________________ ❒Male ❒Female Today's Date______________
Last First Middle Initial mo/day/yr

Address_________________________ Space/Apt #________ City/State____________ Zip________

Home Phone ________________ Cell __________________ Last Four Digits of Social Security #______________

Birth Date________ Age _____ Responsible Party__________ Last Eye Exam ____________________
mo/day/yr mo/yr Doctor Providing Exam

Occupation ____________ Emergency Contact ______________ Relationship__________ Phone__________
Name

❒ Yes-Fulltime Tennessee Resident **❒ No – Part Time Resident-Please provide a secondary address and contact telephone number:**

Email Address: _________________ Secondary Address/Phone: ______________________________

Insurance Information

Please present Insurance & ID cards at front desk to have scanned into records.

1. ❒Y ❒N Vision Insurance? Name: ____________________ Name of Primary Insured:______________
2. ❒Y ❒N Primary Medical Insurance? Name:________________
3. ❒Y ❒N Do you have a Medicare card? Who is your Secondary Insurance? ________________
4. ❒Y ❒N Have you assigned your Medicare benefits over to another company? Who? ______________

Medical History

If you have a written medications list, please give to front desk to have scanned into records.

5. ❒Y ❒N Are you pregnant and/or nursing?
6. ❒Y ❒N Allergies to medications? Explain: ________________________________
7. List any medications you take: (Including Vitamins, OTC Products and Oral Contraceptives):
   ____
   ____
8. List any ocular medication you take: (Eye medications):______________________

Contact Lens Information

9. ❒Y ❒N Do you wear contact lenses?
10. Type of lenses? ____________
11. Replaced how often? ____________
12. ❒Y ❒N Are your contacts comfortable?
13. ❒Y ❒N Any problems with your current contact lenses? Explain:____________

Glasses Information

14. ❒Y ❒N Do you wear glasses?
15. ❒Y ❒N Are you considering refractive Surgery/LASIK? When? __________
16. ❒Y ❒N Do you have Dry Eyes?
17. ❒Y ❒N Do you use Artificial Tears?
18. Number of hours per day on a computer: ______

Family History

19. Please check any family history (parents, grandparents, siblings, children: living or deceased) for the following:

Disease/Condition	Family Relation	Disease/Condition	Family Relation
❒ Blindness	____________	❒ Arthritis/Lupus	____________
❒ Cataracts	____________	❒ Cancer	____________
❒ Crossed Eyes	____________	❒ Diabetes	____________
❒ Glaucoma	____________	❒ Heart Disease	____________
❒ Mac. Degeneration	____________	❒ High Blood Pressure	____________
❒ Retinal Problems	____________	❒ Thyroid Disease	____________
❒ **None of these**		❒ **None of these**	

Social History

This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.

❒ Yes, I would prefer to discuss my Social History Information directly with my doctor (check box).

20. ❒Y ❒N Do you drive?
21. ❒Y ❒N If yes, do you have visual difficulty when driving? Explain:____________________
22. ❒Y ❒N Do you use tobacco products? If yes, type/amount/how long:________________
23. ❒Y ❒N Do you drink alcohol? If yes, type/amount/how long:________________
24. ❒Y ❒N Do you use illegal drugs? If yes, type/amount/how long:________________
25. Have you ever been exposed to or infected with: ❒Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis ❒**None of these**

Personal Ocular History

Please explain if have a condition not listed: ______________________

26. Check any of the following conditions you have had:

❒ Allergy Eyes	❒ Double Vision	❒ Frequent Headaches	❒ Prominent Eyes
❒ Cataracts	❒ Eye Infections	❒ Glaucoma	❒ Retinal Disease
❒ Crossed Eyes	❒ Eye Injuries	❒ Lazy Eye	❒ **None of these**
❒ Drooping Eyelid	❒ Eye Surgery		

TURN OVER →

Personal Medical History

27. **Check any chronic** problems your have had **in the past** or **currently** have:

Allergic/Immunologic
- ❒ allergic/immunologic

Bones/Joints/Muscles
- ❒ rheumatoid arthritis
- ❒ muscle pain

Constitutional
- ❒ fever, weight loss/gain

Ears, Nose, Mouth, Throat
- ❒ allergies/hay fever
- ❒ sinus congestion
- ❒ runny nose
- ❒ post-nasal drip
- ❒ chronic cough
- ❒ dry throat/mouth

Endocrine
- ❒ thyroid/other glands

Eyes
- ❒ permanent loss of vision
- ❒ blurred vision
- ❒ distorted vision/halos
- ❒ loss of side vision
- ❒ double vision
- ❒ dryness
- ❒ mucous discharge
- ❒ redness
- ❒ sandy or gritty feeling
- ❒ itching
- ❒ burning
- ❒ foreign body sensation
- ❒ excess tearing/watering
- ❒ glare/light sensitivity
- ❒ eye pain or soreness
- ❒ infection of eye lid
- ❒ styes or chalazion
- ❒ floaters in vision
- ❒ light flashes

Gastrointestinal
- ❒ diarrhea
- ❒ constipation

Genitourinary
- ❒ genitals/kidney/bladder

Integumentary (skin)
- ❒ integumentary (skin)

Lymphatic/Hematologic
- ❒ anemia
- ❒ bleeding problems

Neurological
- ❒ headaches
- ❒ migraines
- ❒ seizures

Psychiatric
- ❒ psychiatric

Respiratory
- ❒ asthma
- ❒ chronic bronchitis
- ❒ emphysema

Vascular/Cardiovascular
- ❒ diabetes
- ❒ heart pain
- ❒ high blood pressure
- ❒ vascular disease

❒ **I HAVE NONE OF THE ABOVE CONDITIONS.**

28. If you checked any of the above conditions or have a condition not listed, please explain below:

___

Please note:

- Professional fees are not refundable.
- Medicare will not pay for refractive services or routine care. If submitted to Medicare, you will likely be denied reimbursement.
- Prescription rechecks available at no charge for 30 days from original exam by original doctor. Fees apply after 30 days or for second opinion.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

☑ I authorize the release of any medical or any other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment: Dr. Andrew Clarke and Associates.

☑ I authorize payment of medical benefits to Dr. Andrew Clarke and Associates for services rendered. I agree to be financially responsible for any balance not paid by my insurance plan.

HIPAA REGULATIONS

☑ In compliance with HIPAA regulations, all of your information will be kept confidential. I have been presented with the Notice of Privacy Policy of Dr. Andrew Clarke and Associates (the "provider") and have been offered a copy of such policy for my records.

Printed Name of Patient OR Patient's Representative	Signature of Patient OR Patient's Representative	Relationship to Patient (Only indicate if representative)	Date

For office use only:

Doctor's signature: ______________________ **Date:** ______________