# MEDICAL HISTORY QUESTIONNAIRE

Name:_____Date of Birth _____/_____/_____ Today'sDate:____/____/____
Date of Last Eye Exam ____/____/____ Name of Previous Eye Doctor_____

**MEDICAL HISTORY**

Do you have any allergies to medications? □ no □ yes If yes, explain _____
_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):_____
_____

List all major injuries, surgeries and /or hospitalizations you have had:_____
_____

List any of the following that you have had: eye surgery, lazy eye, drooping eyelid, glaucoma, retinal diseases, cataract, eye infections or eye injury:_____
_____

Are you pregnant and/or nursing? □ no □ yes
Do you wear contacts? □ no □ yes
If yes, which Brand_____

Do you have sleep apnea? □ no □ yes
Have you had LASIK or any refractive surgery? □ no □ yes

**REVIEW OF SYSTEMS Do you currently or have you ever had any problems in the following areas:**

| | | | | | |
|---|---|---|---|---|---|
| **Constitutional** | | **Eyes (continued)** | | **Vascular/Cardiovascular** | |
| Fever/weight Loss/Gain | □ yes □ no | Excess Tearing/Watering | □ yes □ no | Diabetes | □ yes □ no |
| **Integumentary (skin)** | □ yes □ no | Eye pain or soreness | □ yes □ no | Heart Disease | □ yes □ no |
| **Neurological** | | Sties or Chalazion | □ yes □ no | High Blood Pressure | □ yes □ no |
| Headaches | □ yes □ no | Flashes or Floaters | □ yes □ no | Vascular Disease | □ yes □ no |
| Migraines | □ yes □ no | Tired Eyes | □ yes □ no | **Gastrointestinal** | |
| Seizures | □ yes □ no | **Endocrine** | | Acid Reflux | □ yes □ no |
| **Eyes** | | Thyroid/Other Glands | □ yes □ no | Diarrhea | □ yes □ no |
| Loss of vision | □ yes □ no | **Ear, Nose, Mouth, Throat** | | Constipation | □ yes □ no |
| Blurred vision | □ yes □ no | Allergies/Hay fever | □ yes □ no | **Genitourinary** | |
| Distortion vision/halos | □ yes □ no | Sinus Congestion | □ yes □ no | Kidney/Genital/Bladder | □ yes □ no |
| Loss of side vision | □ yes □ no | Dry Throat/Mouth | □ yes □ no | **Bones/Joints/Muscles** | |
| Double vision | □ yes □ no | Chronic Cough | □ yes □ no | Rheumatoid Arthritis | □ yes □ no |
| Dryness | □ yes □ no | Post-Nasal Drip | □ yes □ no | Muscle Pain | □ yes □ no |
| Mucouse Dishcarge | □ yes □ no | **Respiratory** | | Joint Pain | □ yes □ no |
| Redness | □ yes □ no | Asthma | □ yes □ no | **Lymphatic/Hematologic** | |
| Itching/Burning | □ yes □ no | Chronic Bronchitis | □ yes □ no | Anemia | □ yes □ no |
| Foreign Body Sensation | □ yes □ no | Emphysema | □ yes □ no | Allergic/Immunologic | □ yes □ no |
| | | | | **Psychiatric** | □ yes □no |

**Briefly mention any other medical or eye conditions you may have that is not listed**:

_____
_____

**Family Eye History:**

□ Blindness:_____
□ Cataract:_____
□ Glaucoma: _____
□ Lazy Eye: _____
□ Macular Degeneration: _____
□ Retinal Detachment/tear:_____

**Family Medical History: (blood relatives have had the following; unmarked answers are negative) OR** □ NONE

□ Cancer: _____
□ Heart Disease:_____
□ High Blood Pressure: _____
□ Arthritis:_____
□ Neurological Disease:_____
□ Kidney / Thyroid / Endocrine_____

□ Diabetes:_____
□ Blood Disease:_____
□ High Cholesterol:_____
□ Respiratory illness:_____
□ Psychological: _____
□ Other:_____

**Social History:** (all information is kept confidential)

Do you drive? □ yes □ no If yes, do you have difficulty when driving? □ yes □ no If yes When? □ Night □ Day and Night
Do you use tobacco products? □ No □ Yes If yes, type/amount/how long_____
Do you drink alcohol? □ No □ Yes □ Socially □ 1-3 days/week □ 3 + days a week
Do you use illegal drugs? □ No □ Yes If yes, type/amount/ how long:_____
Have you been infected with any blood borne or sexually transmitted diseases below: □ Yes □ No (if yes please check or state below)
□ HIV □ Hepatitis □ Syphilis □ Chlamydia

_____

**Date** _____ **Doctors Signature**_____**O.D.**

# PATIENT INFORMATION and CONSENT FORM

Patients Name_____ Date of Birth_____
MailingAddress_____
City_____ State_____ Zip _____
Home Ph (  )_____ Cell Ph (  )_____Work(  )_____
Email address _____ Social Security Number: _____
Primary Care Physician Name _____
City_____ State_____ Phone Number (  ) _____
How did you hear about us?_____

**Electronic Communication Consent** (please check all that apply) ☐ **Text Messaging** ☐ **E-Mail** ☐ **Voice Mail**

## INSURANCE INFORMATION

This office participates with Medicare, Anthem Blue Cross, ConnectiCare, Oxford, EyeMed, United Healthcare, Cigna PPO, Aetna, PHCS and MultiPlan.**If the reason for your visit is related to a medical diagnosis or a medical diagnosis is discovered in the course of an eye exam and you elect for treatment on the same day of service, then your medical insurance will be billed and medical or specialist copays or deductibles will apply. As a courtesy we will do our best to verify benefits and eligibility with your insurance company but it is by no means a guarantee of payment or coverage.**

| **Primary Medical Insurance** | **Secondary or Vision Insurance** |
|---|---|
| Insurance Company_____ | Insurance Company_____ |
| ID#_____ | ID#_____ |
| Group #_____ | Group #_____ |
| Policy Holder Name (☐ self) _____ | Policy Holder (☐ self) _____ |
| Date of Birth_____ | Date of Birth_____ |

_____
Guarantor NAME, ADDRESS and DOB for minor patient (if different from above)

## *PAYMENT IS REQUIRED AT TIME OF SERVICE*

I understand that some or all of the services provided may not be covered by my insurance company. I understand that I am financially responsible for full payment of all charges whether or not paid by insurance. We accept cash, check, MasterCard Visa and Discover. I hereby authorize the doctor to release all information necessary to secure the payment of benefits for services rendered today and at subsequent visits. I acknowledge if my account is sent to a collection agency I will be responsible for my balance and a **$20** collection fee. Returned checks are subject to a **$25** fee. There is also a **$40** charge for all missed and rescheduled appointments without 24 hours advanced notice. We realize that temporary financial problems do arise and we encourage you to contact us promptly for assistance in the management of your account. _____. ( initial)

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

In the course of providing services to you, we create, receive and store your personal information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services (submit insurance claims) and to conduct health care operations (determination of benefits, verifying eligibility for care) involving our office. The form you have been provided describes our privacy policies, the ways in which we use your personal identifying information and the measures in which we go through to protect it. You are free to refer to this document at any time. You have the right to refuse to sign this form however we must provide you with a notice of our privacy practices for your records. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our "Notice of Privacy Practices", we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding upon our office. Please read our "Notice of Privacy Practices".
I've been presented with this document and understand._____. ( initial)Refusal to Sign_____ (Provider Use Only)

_____ _____
Date **Signature** **Relationship to Patient**