MALLARD EYE CARE

Patient History Questionnaire

Office use only:
Chart ID _____
Ins _____
Photos _____

PLEASE PRINT

Last Name: _____ First: _____ MI: ____ Goes by: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender: ____ SS#: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Guardian (if under 18): _____Relation: _____ Date of Birth: _____

E-Mail: _____

Family Doctor: _____ Phone: (____)_____

Occupation: _____ Employer: _____

Last Eye Exam: ____/____/____ Last Medical Exam: ____/____/____

Alternate Contact: _____ Relationship: _____ Phone: (____)_____

Chief complaint today: _____ How did you hear about us? _____

Medical History

Height: _____ Weight: _____ Do you smoke? Yes ___ No ___ Previously ___ Do you drive? ___

Do you have any allergies to Medications: ___Yes ___ No *If Yes, Explain _____

List any medications with current dosages that you are currently taking _____

_____

Check any of the following that you have had: Prominent Eyes ___ Crossed Eyes ___ Lazy Eye ___

Eye Surgery ___ Eye Infection ___ Retinal Disease ___ Glaucoma ___

Cataracts ___ Eye Injury ___ Drooping Eyes ___

Are you pregnant? ___ Y ___ N

Do you wear glasses ___Y ___N If yes, how old is your present pair of glasses? _____ Years

Do you wear contacts ___Y ___N If yes, how old is your present pair of contact lenses? _____ Weeks

What Brand of contacts are you currently wearing? _____ Are they comfortable? ___Y ___N

Retinal Photos

A retinal photo is a picture of the inside of the eye. This technology gives our doctors a better view of the health of your eye. While this is not a replacement for dilation, should you choose to not have your eyes dilated we strongly recommend taking the photos. **If you have a history of eye disease, diabetes, high blood pressure, high cholesterol or family history of eye disease we strongly recommend taking the photos.** Retinal photos are included in the OUT OF POCKET (non-insurance) exam fees. If you are using vision insurance, these photos are typically not covered and the fee is $20. If you are using medical insurance and there is a medical reason to take the photos, we will bill them to your insurance for you. Sometimes dilation is still necessary and the doctor will discuss it with you if it is required for your exam.

_____ I would like to have the retinal photos taken

_____ I prefer not to have the retinal photos taken, unless the doctor and I agree they are necessary

Do you currently or do you often have any problems in the following areas:

CONSTITUTIONAL

- ☐ Fever
- ☐ Weight Loss/Gain

INTEGUMENTARY

- ☐ Skin Changes

NEUROLOGICAL

- ☐ Headaches
- ☐ Migraines
- ☐ Seizures

EYES

- ☐ Loss of Vision
- ☐ Blurred Vision
- ☐ Distorted Vision/Halos
- ☐ Loss of Side Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Mucous Discharge
- ☐ Redness
- ☐ Itching
- ☐ Burning
- ☐ Foreign Body Sensation
- ☐ Excess Tearing
- ☐ Glare/Light Sensitivity

EYES (continued)

- ☐ Eye Pain or Soreness
- ☐ Chronic Infection of Eye or Lid
- ☐ Styes or Chalazion
- ☐ Flashers
- ☐ Floaters in Vision
- ☐ Tired Eyes

RESPIRATORY

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Sleep Apnea

EARS, NOSE, THROAT and MOUTH

- ☐ Seasonal Allergies/Hay Fever
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post-Nasal Drip
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth
- ☐ Ringing In Ears
- ☐ Ear Pain or Infection
- ☐ Hearing Aids
- ☐ Deaf

VASCULAR,CARDIOVASCULAR

- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

GASTROINTESTINAL

- ☐ Diarrhea
- ☐ Constipation

GENITOURINARY

- ☐ Gonads/Kidney/Bladder

BONES/JOINTS/MUSCLES

- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain

LYMPHATIC/HEMATOLOGICAL

- ☐ Anemia
- ☐ Bleeding Problems

ENDOCRINE

- ☐ Thyroid Issues/Other Glands

ALLERGY/IMMUNE

- ☐ Allergies, Immune Disorders

PSYCHIATRIC

- ☐ Psychiatric

Family History

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions.

DISEASE/CONDITION	Y	RELATIONSHIP
Blindness		
Glaucoma		
Crossed Eyes		
Macular Degeneration		
Retinal Detachment/Disease		

	Y	RELATIONSHIP
Cancer		
Diabetes		
Heart Disease		
High Blood Pressure		
High Cholesterol		

HIPPA Privacy Policy

I acknowledge that my medical history may be stored online through Mallard Eye Care's computer system and Dr. First R-Copia E-prescribing. I understand that I may request a detailed copy of Mallard Eye Care's HIPAA Privacy Practices at any time.

****I acknowledge that my personal and medical information can only be discussed with those listed below.****

Patient Signature (or Guardian, if applicable): _____ Date: _____

Names:	**Relationship:**	**Date of Birth:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

MALLARD EYE CARE

Insurance Information

I hereby authorize the use of this signature for all insurance submissions as well as treatment authorization, giving Christopher Mallard, O.D. permission to give me reasonable and proper medical care based on today's standards.

**As of January 1, 2018, Mallard Eye Care will file all exams with a medical diagnosis including Diabetes, Cataracts, Macular Degeneration and Glaucoma through your medical insurance first, then your vision insurance (Coordinating your Benefits). This will offer you the best coverage for your eye exam possible.

Deductibles, coinsurance and/or copays will be billed to you after both insurances have paid.
I understand that I am financially responsible for all charges not paid by insurance.

All patients, please list both Medical and Vision insurance information below.

Medical Insurance: ___________________________________ ID Number: ____________________________________

Primary Beneficiary Name: _______________________________________ Date of Birth: __________________

Vision Insurance: ____________________________________ ID Number: _____________________________________

Primary Beneficiary Name: _______________________________________ Date of Birth: __________________

Patient Name: (printed): ____

Signature: ____ DATE: ________________

(Patient or person authorized to give consent)

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Contact Lens Exam

Cost: $30 for Spherical, $40 for Torics (astigmatism) or Monovision, $50 for Bifocal, $100 for RGP

This includes the contact lens evaluation, diagnostic fit, initial trial pairs, any new-user instructions, and all related follow up care for 60 days. Subsequent visits are subject to regular office visit charges of $35.

If for any reason you wish to discontinue contact lens wear during the initial period, the fees are non-refundable. Your contact lens prescription will expire 1 year after the initial fitting date, per government regulations.

If you would like more detailed information about contact lens exam and wear instructions, please ask us.

I understand the above practices of Mallard Eye Care and that I wear contact lenses at my own risk. I also agree to use standardized wear and care procedures when using contact lenses to reduce the chances of complications.

Patient Signature: ____

Also Guardian Signature (if under the age of 18): ____
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