Medical History Questionnaire

Patient Name: _____ Today's Date: _____/_____/_____
Address: _____ Home Phone: _____
City: _____ Zip Code: _____ Cell Phone: _____
Date of Birth: _____/_____/_____ Occupation: _____
Name of Medical Doctor: _____ Marital Status: _____
How did you hear about us: _____ **Email:** _____

Medical History:

Do you have any allergies to medications? ☐Yes ☐No If Yes, Please 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: _____

_____

Check any of the following that you have had: ☐ Crossed Eyes ☐ Lazy Eye ☐ Drooping Eyelid, ☐ Prominent Eyes
☐ Glaucoma, ☐ Retinal Disease, ☐ Cataracts, ☐ Eye Infections, ☐ Eye Surgery ☐ Eye Injury

Are you pregnant and/or nursing? ☐ Yes ☐No

Do you wear glasses? ☐ Yes ☐ No If Yes, How old is your current pair: _____

Do you wear contact lenses? ☐ Yes ☐ No If Yes, how old is your present pair: _____

Family History:

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

Disease/Condition	Yes	No	?	Relationship to you
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____

Other: _____

(Please Complete Both Sides)

Social History

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

☐Yes, I would prefer to discuss my social history information directly with the doctor.

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No

If yes, please describe _____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you drink alcohol" ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently or have you ever had any problems in the following areas:

System	Yes	No	?		Yes	No	?
Constitutional				**Ears, Nose, Mouth, Throat**			
Fever, Weight Loss/Gain	☐	☐	☐	Allergies/Hay Fever	☐	☐	☐
Integumentary (Skin)	☐	☐	☐	Sinus Congestion	☐	☐	☐
Neurological				Runny Nose	☐	☐	☐
Headaches	☐	☐	☐	Post Nasal Drip	☐	☐	☐
Migraines	☐	☐	☐	Chronic Cough	☐	☐	☐
Seizures	☐	☐	☐	Dry Throat/Mouth	☐	☐	☐
Eyes				**Respiratory**			
Loss of Vision	☐	☐	☐	Asthma	☐	☐	☐
Blurred Vision	☐	☐	☐	Chronic Bronchitis	☐	☐	☐
Distorted Vision/ Halos	☐	☐	☐	Emphysema	☐	☐	☐
Loss of Side Vision	☐	☐	☐	**Vascular/Cardiovascular**			
Double Vision	☐	☐	☐	Diabetes	☐	☐	☐
Dryness	☐	☐	☐	Heart Pain	☐	☐	☐
Mucous Discharge	☐	☐	☐	High Blood Pressure	☐	☐	☐
Redness	☐	☐	☐	Vascular Disease	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐	**Gastrointestinal**			
Itching	☐	☐	☐	Diarrhea	☐	☐	☐
Burning	☐	☐	☐	Constipation	☐	☐	☐
Foreign Body Sensation	☐	☐	☐	**Genitourinary**			
Excess Tearing/Watering	☐	☐	☐	Genitals/Kidney/Bladder	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐	**Bones/Joints/Muscles**			
Eye Pain or Soreness	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Chronic Infection Eye/Lid	☐	☐	☐	Muscle Pain	☐	☐	☐
Sties or Chalazion	☐	☐	☐	Joint Pain	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐	**Lymphatic/Hematologic**			
Tired Eyes	☐	☐	☐	Anemia	☐	☐	☐
Endocrine				Bleeding Problems	☐	☐	☐
Thyroid/Other Glands	☐	☐	☐	**Allergic/Immunological**			
				Psychiatric	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____ _____

Doctor's Signature Date

Retinal Evaluation Consent

Dilated Eye Exam

The dilation is **included in your exam fee**. These drops make the pupils larger allowing the doctor to accurately assess your ocular health. The dilation procedure adds an additional 30 minutes to the exam. The drops will cause light sensitivity and blurred near vision for 4-6 hours.

iWellness® Exam

We are pleased to offer the latest in retinal imaging. The iWellness® exam uses breakthrough technology called spectral domain optical coherence tomography or SD-OCT. Similar to an MRI or CT scan, the iWellness® exam captures high definition cross sectional images of your retina, which is the back of your eye. It allows the doctor to see in unprecedented clarity what may be invisible with traditional examination methods, including retinal photography. The images can be shared allowing you and the doctor to discuss the findings together. This is not covered by your insurance and the **fee is an additional $39.** We highly recommend this imaging for all patients previously diagnosed or who have a family history of diabetes, hypertension, high cholesterol, macular degeneration and glaucoma. Imaging is also recommended for everyone to serve as a baseline for future evaluations.

I agree to:

- ❑ **Dilation (included in exam fee)**

  or

- ❑ **iWellness® Exam (fee is $39)**

Contact Lens Exams Office Policy

Please be aware that in most cases the contact lens exam is **not covered by insurance**. If you agree to this exam, a fee will be charged. Full payment is due at the time of service. Contact lens exams are necessary to update your contact lens prescription.

- ❑ **Yes, I would like a contact lens exam**
- ❑ **No, I decline this exam**

All required contact lens follow-up visits must be completed **within 60 days of your exam**. Also, if you have any concerns regarding your exam you must bring it to our attention within 60 days of your exam. During this time, we will be happy to assist you at no additional charge. However, after 60 days you will be charged an office visit fee.

Insurance Information, Financial Responsibility, HIPAA & Contact Lens Exam Office Policy

Insurance Information

To provide you the best service and assure the timely processing of your insurance claims, please provide your insurance information.

Name of Insurance:_____

Insurance ID Number: _____

Name of Policy Holder: _____

Policy Holders Date of Birth: _____

Policy Holders Social Security Number:_____

Financial Responsibility Statement

Your insurance is a method for you to pay for products and services rendered. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages based on your plan. You are usually responsible for any charges above these amounts. It is your responsibility to pay in advance for the deductibles and co-insurance fees. We will assist you in recovering reimbursement for your remaining balance as much as possible but you are responsible for the full balance.

You or the guarantor are ultimately responsible for all charges for products and services rendered in our office. There are no exceptions.

If any outstanding balance remains after 90 days, we reserve the right to use an outside collection agency to assist in the recovery of the delinquent account. All associated fees will be charged to the patient or guarantor of the account.

HIPAA Receipt

By signing below, you acknowledge that you have been offered a copy of the office's Notice of Privacy Practices.

By signing this statement you agree to all terms shown on both sides.

Patient or Guardian E-Mail: _____

Patient or Guardian Signature: _____ Date: _____

Patient's Name (Print): _____