

Medical History Questionnaire

Name: _____ Date of Birth: _____ Today's Date: _____

Please assist us in providing you with the most up to date eye care available by telling us a little about your health history.

What brings you in to see us today? (circle all that apply)

Eye exam **Laser Vision Correction** **New glasses** **New contacts** Other: _____

When was your last eye exam? _____ Name of the Eye Doctor _____

Are you currently wearing contact lenses? **Yes / No** Have you ever worn contact lenses? **Yes / No**

Have you noticed any changes in your vision with your correction on? Y / N
If yes, do you notice it more in your distance vision, near vision, or both? Distance / Near

When was your last physical _____ What is your family doctor's name _____
How many hours per day, on average, do you use a computer? _____

Patient's Medical History

Please **circle yes (Y)** below if YOU currently have any of the following or **no (N)** if you have not.

| | | | |
|-------------------------------|-----------------------------|--------------------------------|--|
| CONSTITUTIONAL | GASTROINTESTINAL | ENDOCRINE | Y N Blindness |
| Y N Fever, Weight Loss/Gain | Y N Diarrhea | Y N Diabetes | Y N Strabismus |
| EARS/NOSE/MOUTH/THROAT | Y N Constipation | Y N Hyper/Hypo Thyroid | Y N Lazy eye / Crossed eyes |
| Y N Sinus Congestion | MUSCULOSKELETAL | HEMATOLOGIC / LYMPHATIC | Y N Amblyopia |
| Y N Dry Throat/mouth | Y N Rheumatoid Arthritis | Y N Anemia | Y N Blurry Vision with correction |
| CARDIOVASCULAR | Y N Muscle pain | Y N Bleeding problems | Y N Tired eyes |
| Y N Heart pain | Y N Joint Pain | ALLERGIC / IMMUNOLOGIC | Y N Decreased vision |
| Y N High Blood Pressure | INTEGUMENTARY (SKIN) | Y N Lupus | Y N Dryness |
| Y N Vascular Disease | Y N Eczema, skin cancer | Y N Allergies / Hay Fever | Y N Burning |
| Y N Heart Surgery | NEUROLOGICAL | EYES | Y N Itching |
| RESPIRATORY | Y N Headaches | Y N Glaucoma | Y N Double vision |
| Y N Asthma | Y N Migraines | Y N Cataracts | Y N Eye pain |
| Y N Chronic Bronchitis | Y N Seizures | Y N Diabetic Retinopathy | Y N Floaters or Light flashes |
| Y N Emphysema | PSYCHIATRIC | Y N Macular Degeneration | Y N History of eye surgeries |
| GENITOURINARY | Y N Depression, Anxiety | Y N Retinal Detachment | |
| Y N Dialysis, kidney failure | | Y N Retinal Disease | |
| | | Y N Eye/head injury | |

Family Medical History

Please **circle yes (Y)** below if anyone in your family has a history of any of the following or **no (N)** if they do not.

| | |
|--------------------------|---|
| Y N Glaucoma | If yes, please list their relation to you _____ |
| Y N Cataracts | If yes, please list their relation to you _____ |
| Y N Diabetes | If yes, please list their relation to you _____ |
| Y N Macular degeneration | If yes, please list their relation to you _____ |
| Y N Retinal disease | If yes, please list their relation to you _____ |
| Y N Blindness | If yes, please list their relation to you _____ |
| Y N Crossed eyes | If yes, please list their relation to you _____ |
| Y N Thyroid disease | If yes, please list their relation to you _____ |
| Y N Heart disease | If yes, please list their relation to you _____ |
| Y N High blood pressure | If yes, please list their relation to you _____ |
| Y N Arthritis | If yes, please list their relation to you _____ |

Are you taking any medications (including eye drops)? **Yes / No** If so please list the name and purpose of the medication.

Do you have any allergies to medications? **Yes / No** If so please list them;

Is there any information on this questionnaire that was not addressed that you would like the Doctor to be aware of? If so, please list it here.

Welcome to Total Eye Care

PATIENT INFORMATION

Today's Date _____ / _____ / _____

Name (Mr./Mrs./Ms.) _____ (First, M., Last) Nickname _____

Date of Birth _____ Social Security # _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

E-mail _____ Cell Phone _____

Occupation _____ Employer/School _____

How did you hear about our office _____

Family Members

| | | | | | | | |
|-------|------|-------|-----|-------|------|-------|-----|
| _____ | Name | _____ | Age | _____ | Name | _____ | Age |
| _____ | Name | _____ | Age | _____ | Name | _____ | Age |
| _____ | Name | _____ | Age | _____ | Name | _____ | Age |

RESPONSIBLE PARTY INFORMATION

(For patients under 18 years of age)

Name (Mr./Mrs./Ms.) _____ (First, M., Last) Relationship to Patient _____

Date of Birth _____ Social Security # _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

E-mail _____ Cell Phone _____

Occupation _____ Employer/School _____

PRIVACY PRACTICES AND FINANCIAL RESPONSIBILITY

I acknowledge that a copy of Total Eye Care's Notice of Privacy Practices has been made available to me. I agree to be responsible for any fees incurred as a result of failure to pay for all services and/or materials provided, including reasonable collection fees.

Signature _____
(Please circle one: Patient or Guardian)

EMERGENCY CONTACT INFORMATION

(Not in the same household)

Name (Mr./Mrs./Ms.) _____ Relationship to Patient _____
(First, M., Last)

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

E-mail _____ Cell Phone _____

FINANCIAL RESPONSIBILITY (INSURANCE)

We will be happy to file your insurance claim forms or to take assignment of your vision and/or medical benefits as designated by your insurance company. We are happy to provide this service without any additional charge to you. We will do all that we can to help you receive the maximum benefits.

We go to great lengths to verify the amount and type of coverage you are allowed under your plan. We can quote your estimated coverage, however, final determination of your benefits will not occur until the insurance company receives your claim. In the event the Plan Sponsor determines that you are not eligible at the time of service, makes a determination that you are eligible for a reduced level of coverage, or applies the charges to your deductible, by signing this statement, you agree to be financially responsible for any and all of the charges incurred by you and not paid by the Plan Sponsor.

Signature _____
(Please circle one: Patient or Guardian)

VISION INSURANCE INFORMATION

Name (Mr./Mrs./Ms.) _____ Relationship to Patient _____
(First, M., Last)

Date of Birth _____ Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Member Employer _____ Name of Insurance Company _____

Member ID _____ Group Number _____

MEDICAL INSURANCE INFORMATION

Name (Mr./Mrs./Ms.) _____ Relationship to Patient _____
(First, M., Last)

Date of Birth _____ Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____

Member Employer _____ Name of Insurance Company _____

Member ID _____ Group Number _____

Please return this form to the Receptionist with your insurance cards