Family Eye Care Center

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ACKNOWLEDGEMENT

We, the Family Eye Care Center, acknowledge that we will not release patient records without consent of the patient and or legal guardian as noted in our Notice of Privacy Practices. A copy of this policy is available at the request of the patient and or legal guardian.

I acknowledge that on _____ day of _____, 20_____,

I was offered a copy of Family Eye Care Center's

Notice of Privacy Practices.

_____

or _____

Legal Guardian or Personal Representative

Vision Questionnaire

Thank you for assisting us to better serve your eye health and vision needs!

Name:_____

Email*:_____

*Required to send a link for you to access your medical record summary via a secure web portal.

1. What is your occupation? _____

2. What ways do you use your glasses? (Check all that apply)

____Cards/crossword puzzles ____Fishing, Boating ____Computer/____hrs per day
____Power tools ____Sewing/needlework ____Reading
____Gun Range shooting ____Other_____

3. What is it you like the most about your glasses (e.g. color, size, shape)?

4. What would you like to change about your glasses?

5. Are any of your sunglasses polarized? Yes No Unsure Do Not Have Sunglasses

****To stay in compliance with the National Health Care Act as of July 15, 2011 we need to record the following information for your health care record.****

Current height?_____ Current weight?_____

___Current some day smoker ____Current every day smoker ____Former smoker ___Heavy tobacco smoker
___Light tobacco smoker ____Smoker, current status unknown ___Never smoker ___Unknown if ever smoked

FAMILY EYE CARE CENTER

U.S. HITECH Act Demographics Patient Questionnaire

****To stay in compliance with the National Health Care Act as of July 15, 2011 we need to record the following information for your health care record****

Legal Name: _____

Date of Birth: _____ **Birth State:** _____

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Pt. Declined to Answer

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Pt. Declined to Answer

Height: _____ **Weight:** _____

Smoking Status:

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Smoker
- ☐ Former Smoker
- ☐ Never smoker

Email address: _____

Required to send a link for you to access your medical record summary via a secure web portal.

If you have any questions or concerns in regard to this questionnaire please refer to the information on the back side of this sheet. Thank you.

Medical History Questionnaire

Name: _____ Today's Date: _____
First *Middle Initial* *Last*

Address: _____ Home Phone: _____

_____ Work Phone: _____

Birth Date: _____ Birth State: _____ Cell Phone: _____

Patient's Employer: _____ Occupation: _____

Social Security #: _____ Email: _____

Spouse: _____ Spouse's Birth Date: _____

Whom may we thank for referring you to us: _____

IF DEPENDENT PLEASE FILL IN THE NEXT SECTION:

Mother's Name: _____ Home Phone: _____

Mother's Employer: _____ Work Phone: _____

Father's Name: _____ Home Phone: _____

Father's Employer: _____ Work Phone: _____

Nearest Relative Not Living with You: _____

Address: _____ Phone: _____

FAMILY EYE CARE CENTER PAYMENT POLICY & INSURANCE RELEASE: Please read this document carefully & sign to assure us you understand our insurance release & payment policy. This document will become a part of your permanent record at the Family Eye Care Center. All services are to be paid for in full at the time they are received (unless charges are being filed to an insurance plan we participate in). Any charges not paid by said insurance will become your full responsibility. All insurance copays are to be paid at the time of service. All materials are to be paid in full at the time they are ordered. You will receive a 5% discount as a thank you for your prompt payment.

I understand the above insurance release and payment policy.

Signature _____ Date _____

MEDICAL HISTORY:

Name of Medical Dr.: _____ Doctor's Phone: _____

Date of last Medical Exam: _____

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: _____

_____

Date of last Eye Exam: _____

List any ocular(eye) surgeries, trauma or significant infections you have had: _____

_____

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

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

Contact lenses (Rigid, Soft, Extended Wear): _____ Are they comfortable: _____

OVER

Review of Systems *Do you currently, or have you ever had any problems in the following areas:*

	No	Yes	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
CARDIOVASCULAR			
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
EAR, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus congestion	☐	☐	☐
Post Nasal Drip	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
MUSCULOSKETAL			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
INTEGUMENTARY (skin)			
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
PSYCHIATRIC			
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
Diabetes	☐	☐	☐
HEMATOLOGIC/LYMPHATIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC/IMMUNOLOGIC			
OTHER			
Cancer	☐	☐	☐
EYES			
Macular Degeneration	☐	☐	☐
Amblyopia	☐	☐	☐
Cataracts	☐	☐	☐
Glaucoma	☐	☐	☐
Retinal Detachment	☐	☐	☐
Dry Eye Syndrome	☐	☐	☐
Floaters	☐	☐	☐
Strabismus	☐	☐	☐
Eye Injury	☐	☐	☐
Diabetic Retinopathy	☐	☐	☐
Blindness	☐	☐	☐
Blurred Vision	☐	☐	☐
Double Vision	☐	☐	☐
Redness	☐	☐	☐
Tired Eyes	☐	☐	☐
Watery Eyes	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Sandy/Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐

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

_____

_____

_____

Please note any **FAMILY HISTORY** (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	**NO**	**YES**	**?**	**RELATIONSHIP TO YOU**
Amblyopia	☐	☐	☐	_____
Blindness	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Strabismus	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart disease	☐	☐	☐	_____
Hypertension	☐	☐	☐	_____
Family History Unknown	☐	☐	☐	_____
Other Disease	☐	☐	☐	_____

Social History: *This information is kept strictly confidential. However, you may discuss this portion with Doctor if you prefer.*

☐ *Yes, I would prefer to discuss my Social History information directly with Doctor.*

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes If yes, please describe:

_____

_____

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

Do you drink alcohol? ☐ no ☐ yes If yes, type/amount/how long: _____

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

Patient/Guardian Signature _____