Medical History Questionnaire

Today's Date _____ / ______ / ______

Last Name: ______________________________ MI: ____ First Name: _________________________________

Address: _________________________________City: _____________________ State: _____ Zip: __________

Birth Date: _____ / _____ /_______ Social Security #: _____ / ____ / _____ Martial Status: S M W D

Home Phone: ___________________Work Phone: ___________________

Cell Phone: _______________________ Texting Reminder: No☐ Yes☐

NOTE: All patient information is kept **strictly** confidential. Your address and number is **NEVER** shared.

E-Mail: ____ Email Reminder: No☐ Yes☐

Employer: ______________________________________ Occupation: _________________________________

Last Eye Exam: _____ / _____ / _____ Height: ______ Weight: ______ (approx)

Primary Care Physician: ____

Phone #: _______________________________ Last Medical Exam: ____ / ____ / _____

Whom may we thank for referring you? ____

Insurance Information

Medical Insurance Name: ________________________ ID #: _______________________ Grp#:___________

Eye Insurance Name: ___________________________ ID #: _______________________

Primary Insured Member: ____________________________ D.O.B. ____ / ____ /______ S.S.# ____________

Primary Insured's Employer: _______________________________ Occupation: _________________________

Medical History

Do you have any allergies to medications? No☐ Yes☐ If yes, explain: ___________________________

List any medications that you currently take (including contraceptives, aspirin, over the counter medications):

____

____

____

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

____

____

Family History

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

Disease/Condition	No	Yes	??	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 ____________	☐	☐	☐	________________

Social History

Do you drive? No☐ Yes☐

If yes do you have difficulty seeing when driving? No☐ Yes☐ Please explain:____________________

Do you wear glasses? No☐ Yes☐ If yes, how old is your present pair of lenses?____________

Do you wear contact lenses? No☐ Yes☐ If yes, how old is your present pair of lenses?____________

Do you sleep in your contacts? No☐ Yes☐

Type of contact lenses: Rigid☐ Soft☐ Extended Wear☐ Other☐

Are they comfortable? No☐ Yes☐

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: ____________________

Have you ever been exposed to or infected with: Gonorrhea☐ Hepatitis☐ HIV☐ Syphilis☐ None☐

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

Review of Systems

Do you currently, or within the last year have you had any problems in the following areas:

SYSTEM	No	Yes	??
EYES			
Crossed eyes	☐	☐	☐
Lazy eye	☐	☐	☐
Drooping eyelids	☐	☐	☐
Prominent eyes	☐	☐	☐
Glaucoma	☐	☐	☐
Corneal disease	☐	☐	☐
Retinal disease	☐	☐	☐
Cataracts	☐	☐	☐
Eye infections	☐	☐	☐
Eye injuries	☐	☐	☐
Loss of vision	☐	☐	☐
Blurred vision	☐	☐	☐
Distorted vision/halos	☐	☐	☐
Loss of side vision	☐	☐	☐
Double vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy/gritty feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign body sensation	☐	☐	☐
Excess watering	☐	☐	☐
Glare/light sensitivity	☐	☐	☐
Eye pain or soreness	☐	☐	☐
Chronic infection of eye or lid	☐	☐	☐
Sties or chalazion	☐	☐	☐
Flashes/Floaters in vision	☐	☐	☐
Tired eyes	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐

	No	Yes	??
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High blood pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle pain	☐	☐	☐
Joint pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding problems	☐	☐	☐
ENDOCRINE			
Thyroid/ other glands	☐	☐	☐
CONSTITUTIONAL			
Fever, weight loss/gain	☐	☐	☐
EARS, NOSE, MOUTH, THROAT			
Allergies/ hay fever	☐	☐	☐
Sinus congestion	☐	☐	☐
Runny nose	☐	☐	☐
Post-Nasal drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry throat/mouth	☐	☐	☐
INTEGUMENTARY (skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

Dilation Consent

Dilation of the eyes may be necessary in allowing the doctor to detect certain diseases and other vision problems. This procedure is mandatory if you have certain diseases such as diabetes or high blood pressure. The side effects from the dilation are blurred vision at near and light sensitivity that **may last approximately 3 hours.** There may be an additional fee for this procedure if it is not covered by your insurance. If necessary, will you allow for dilation? No☐ Yes☐

Visual Fields Consent

The computerized visual fields machine may be necessary for your doctor to check for missing spots in your peripheral vision that can be present from a variety of ocular diseases such as glaucoma or stroke. **There may be an additional fee for this procedure if it is not covered by your insurance.** If necessary, will you allow for visual fields testing? No☐ Yes☐
Please note: We will let you know the cost before we do any testing.

Patient Signature (parent if minor) ____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name ____ Birth date________________

Signature (parent if minor) ____________________________________

Date ____

PAYMENT POLICY: **Payment is expected at the time services are rendered. Contact lenses require payment prior to ordering. Glasses require full payment prior to dispensing.** Uncollected fees, either from insurance, insufficient funds check, stop payment, credit card chargebacks, etc. remain the responsibility of the patient (parent or legal guardian, if a minor). When insurance benefits are verified, the information provided by the customer service representative is **NOT A GUARANTEE OF PAYMENT**. There may be additional fees for co-pays, deductibles and non-covered services after payment is received from the insurance company. By signing this statement, you agree to be financially responsible for any and all charges.

ASSIGNMENT OF BENEFITS: (Only applicable if we are filing with a Vision or Medical Insurance for you).

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________________
And assign directly to Shah Eye Care, PA all insurance benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Relationship Date