Today's Date: _____

Medical History Questionnaire

Legal Name: _____

(first) (M.I.) (last)

Birth Date: ____ / ____ / _____ Social Security #: _____ / ____ / _____

Address: _____

City & State: _____ 9 digit zip:_____-_____

E-mail address: _____ y / n may we contact you

Phone: _____ y / n may we contact you

Person Responsible for Billing: _____

Name of ***VISION*** Ins. Company to be billed: _____

Secondary ***VISION*** Inc:_____

Circle: F/M, Married, Single, Widowed, Other

Previous Last Name? _____

Name of Medical Dr:_____

Dr's Phone:_____

Last Medical Exam: _____ /_____ / _____

Name of Medical Ins:_____

Secondary Med Ins:_____

Employer: _____

Medical History

Do you have 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 any major injuries, surgeries and/or hospitalization you have had: _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

_____

Are you pregnant and/or nursing? ☐ **no** ☐ **yes**

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?_____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other ☐ Are they comfortable? ☐ **no** ☐ **yes**

Family History

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

DISEASE/CONDITION	NO	YES	OTHER/?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor* (check box) ☐ yes, I would prefer to discuss my Social History information directly with my 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: _____

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	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
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	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

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

_____

_____

_____

Doctor's Signature

Date

Cascade Eye Care

950 11th Avenue

Longview, WA 98632

FINANCIAL AGREEMENT

We are billing your insurance as a courtesy. If you have a secondary or supplemental insurance, please present it at the time of service.

You are authorizing payment directly to Cascade Eye Care of all insurance and health plan benefits.

If you are applying for payment under Medicare or Medicaid, you are authorizing benefits to be paid to Cascade Eye Care on your behalf.

YOU ARE responsible for your co-pays and annual deductibles, when applicable. You WILL BE CHARGED a $20 service fee if you do not pay your co-pay within 30 days.

Please be advised that quoted benefits are not a guaranty of payment. Benefits are subject to contract exclusions, and eligibility at the time of service. Reimbursement is based on allowed amount, unless otherwise indicated. If a patient receives services from a non-contracted provider, the patient may be billed the difference between insurance allowed amount and the providers charge. Under any circumstances, the patient is responsible for their office visit and any order that is placed.

Signature of patient or patient's agent	Relationship	Date
Signature of patient or patient's agent	Relationship	Date
Signature of patient or patient's agent	Relationship	Date
Signature of patient or patient's agent	Relationship	Date
Signature of patient or patient's agent	Relationship	Date
Signature of patient or patient's agent	Relationship	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have been informed of the privacy notice copy available to me at this office.
(Print Name of Patient)

Date of Birth_____

_____
(Signature)

_____
(Date)

_____
(Relationship to patient)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining achknowledgement

_____ Other (Please Specify)

_____

_____

_____
(Team Members Signature)

Please bring in your insurance cards so we can make photocopies.

If you take a lot of medications, please bring a medication list.

Thank you and we hope to see you soon!