Family Eyecare Associates

Welcome to our Practice!

Medical History Questionnaire

Personal Information:

Last Name:____________________________ First Name:_______________ MI:___ Sex: M F DOB:________ Age: _____
Mailing Address:____ City:___________________________ State:_____ Zip:_______
Home Phone:(____)_____-______ Cell Phone:(____)_____-______ Work Phone:(____)_____-______ S.S.#:________________
May we leave messages on your answering machine/voicemail? Y N
E-mail Address:_____________________Would you like to receive e-mails from us about vision care and specials? Y N (limit 1/mo max)
Occupation:______________________ Employer:__________________________ Spouse/Parent Name:_____________________
Emergency Contact:________________________________Relationship:_____________________ Phone: (___)______-_________
Medical Doctor:______________________ Address/Fax:___________________________ Phone:(___)____-____ Last Visit:______

New Patients Only:

How did you hear about our practice?______________Whom may we thank for recommending our office? ___________________
Previous Eye Doctor: _____________________Phone:(___)____-_____ Last Eye Exam:_______ Were your eyes Dilated? Y N

Medical History:

Do you have any allergies to medications? Y N If yes, please list them: ____
List any medications you take (include oral contraceptives, over the counter, and home remedies):__________________________
____
List all major surgeries, injuries and/or hospitalizations you have had (including **EYE** surgeries/injuries):_____________________
____

♦**Review of Systems:** Do you currently, have you ever had any problems or is there a family history in the following areas? (Select Y, N or FAM- for family history, & condition):

Condition				Condition			
Fever, Weight loss/gain	Y	N	FAM	Genitals / Kidney / Bladder	Y	N	FAM
Skin condition	Y	N	FAM	Rheumatoid Arthritis	Y	N	FAM
Headaches / Migraines / Seizures	Y	N	FAM	Muscle pain / Joint pain	Y	N	FAM
Thyroid / Other glands	Y	N	FAM	Anemia / Bleeding problems	Y	N	FAM
Allergies / Sinus	Y	N	FAM	Immunologic	Y	N	FAM
Chronic Cough / Dry throat or mouth	Y	N	FAM	Mental Health	Y	N	FAM
Asthma	Y	N	FAM	**Eyes:** Loss of vision halos crossed eyes sties flashes			
Chronic Bronchitis / Emphysema	Y	N	FAM	double vision mucous discharge redness itching			
Diabetes	Y	N	FAM	sandy feeling floaters burning light sensitivity			
High Blood Pressure / Vascular Disease	Y	N	FAM	water	Y	N	FAM
Diarrhea / Constipation	Y	N	FAM	Eye diseases:_________________________	Y	N	FAM

**If you answered YES to any of the above or have a condition not listed, please explain: ______________________________
____
____

♦**Family History:** Please note any family history (parents, grandparents, siblings, children; living or deceased) for the above conditions:

Condition___________________ Relationship to you__________ Condition__________________ Relationship to you__________
Condition___________________ Relationship to you__________ Condition__________________ Relationship to you__________

♦**Additional Ocular History:**

Do you wear any type of vision correction? Glasses Contacts Both How old are your glasses? __________________
Type of contact lenses: Hard Soft other Brand:______________________ Are they comfortable? Y N
What are your main vision needs? (Work, Hobbies, etc.) ____

Do you…					
Have eyestrain w/ prolonged computer use?	Y	N	Currently wear or have worn contact lenses?	Y	N
Want information on thinner, lighter lenses?	Y	N	Have an interest in trying contact lenses?	Y	N
Have an interest in prescription sunglasses?	Y	N	Have an interest in vision corrective surgery?	Y	N
Have problems w/ night glare or reflection?	Y	N	Struggle w/ dry eyes?	Y	N
Use special or protective eyewear?	Y	N	Have family members in need of eyecare?	Y	N

Please turn this form over and complete side two

**Please check one of the following regarding dilating your eyes:

________ **YES**, if recommended by the Doctor, I would like my eyes dilated today for an additional fee. (Most insurance companies will cover this important procedure.)

________ **NO**, I decline this procedure even if the Doctor feels it is medically necessary to evaluate the health of my eyes.

Social History: *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. Select "Y" if you would prefer to discuss your social history with the doctor. Y*

Do you drive? Y N If yes, do you have visual difficulty when driving? Y N

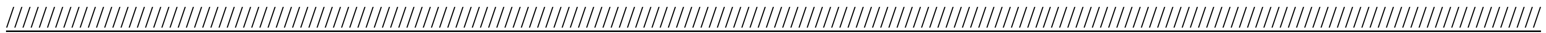
If yes, please describe: ____

Do you use tobacco products? Y N If yes, type / amount / how long:________________________

Do you drink alcohol? Y N If yes, type / amount / how long:________________________

Do you use illegal drugs? Y N If yes, type / amount / how long:________________________

Signature:____ Date completed:____________________



For Future Visits:

I have reviewed the above information and it is still correct or I have made corrections:

Signature:______________________ Dilation Preferred: Y N Date completed:____________________

Signature:______________________ Dilation Preferred: Y N Date completed:____________________

Signature:______________________ Dilation Preferred: Y N Date completed:____________________

Signature:______________________ Dilation Preferred: Y N Date completed:____________________

Signature:______________________ Dilation Preferred: Y N Date completed:____________________

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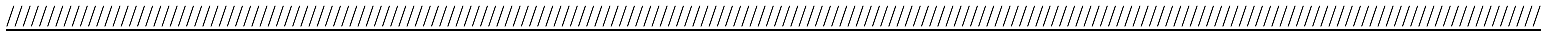
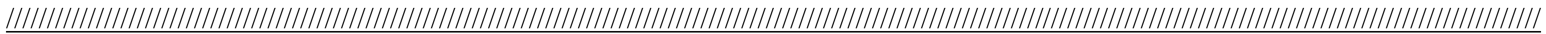


INSURANCE & MEDICARE PATIENTS

I request payment or authorized insurance benefits be made either to me or on my behalf to Family Eyecare Associates for any services furnished to me by the physicians and authorize any holder of medical information about me to release to the insurance company of Health Care Financing Administration and its agents any information needed to determine benefits payable for related services.

Signature________________________________ Date_______________



VISION CARE ELIGIBILITY WAIVER

I certify that I am eligible for coverage through ______________________________ as of ________________.
(Plan Name – Please Print) (Date)

I have chosen Family Eyecare Associates as the provider of my eye care services. I understand that if I am found to be ineligible, I am responsible for all costs incurred in the delivery of services to me and agree to pay these charges.

____ ______________________

Signature of Patient or Guardian Date

____ ______________________

Doctor's Signature Date