Medical History Questionnaire

Name: _____ Today's Date: _____/_____/_____

Address: _____ Phone: ( ) _____

_____ Work Phone: ( ) _____

Date of Birth: _____/_____/_____ Social Security #: _____ - _____ - _____ Last Eye Exam: _____/_____/_____

Name of Medical Doctor: _____ Dr's Phone #: ( ) _____

Last Medical Exam: _____/_____/_____

MEDICAL HISTORY

Do you have any allergies to medications? ☐ no ☐ yes If yes, explain: _____

_____

List all 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: _____

_____

Circle the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts eye infections, eye injury. Explain: _____

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? ☐ yes ☐ no

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	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

- Please complete reverse side -

Social History

This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

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 ☐ Hepatitus ☐ 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 and list medications:

_____

_____

_____

_____ _____

Doctor's Signature Date

MEDICARE Medicare # Effec.Date Birthdate

COVERAGE OVERVIEW

As one of our patients age 65 and older, Medicare is your primary health insurance. For your convenience, our office is a participating provider with Medicare. This means that our office bills Medicare for your office visits, tests and materials. Medicare then reviews all submitted claims and if approved, reimburses our office 80% of the approved amount. The remaining 20% (the co-payment) is your responsibility as the Medicare beneficiary. You may also be responsible for a deductible and certain non-covered fees, as described below. Our office may elect to: 1) bill you directly for your portion of the fees, or 2) bill your supplemental insurance , if you carry it.

Suppl. Ins. ❒No ❒Yes Carrier Name _____

Address _____

Policy # _____ Effec. Date _____

DEDUCTIBLE

Medicare has a yearly deductible of $100 that takes effect each January. If our office is the first to submit Medicare claims for you each year, Medicare will notify us that you have not yet met your deductible for the year. Medicare will not pay for your allowable fees until the deductible has been met.

EXCEPTIONS, NON-COVERED SERVICES & MATERIAL FEES

❒ Medicare does not pay forrefractive services. This is the part of your eye exam that determines your prescription.

❒ Medicare will only pay for services that it determines to be "reasonable and necessary" under code section 1862(a)(1). If Medicare determines that a particular service, although it would be otherwise covered, is not "reasonable and necessary" under their standards, Medicare will deny payment for that service. The doctor believes that, in your case, Medicare is likely to deny payment.

For _____ because _____

For _____ because _____

For _____ because _____

AUTHORIZATION STATEMENT/SIGNATURE

I have read and understand the information above and agree to pay for any services which are not covered by Medicare.

Patient/Beneficiary Signature _____ Date _____

Print Name _____