Medical History Questionnaire

Date: _____

PATIENT INFORMATION:

E-mail _____

Name _____ Nickname _____

Mr. Mrs. Ms. Miss Dr. First MI Last

Address _____ Telephone (Home) _____

City and zip code

Date of Birth _____ Gender M F Telephone (Cell) _____

Social Security# _____ Telephone (Work) _____

Occupation _____ Employer _____

Spouse/Parent for Children _____ Employer _____

Name of Vision Insurance _____

Name of Policy Holder _____ Social Security # _____

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

I would prefer to discuss my Social History information directly with my doctor. (check box)

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 If yes, Type / amount / how long: _____

Do you use alcohol products? Y N If yes, Type / amount / how long: _____

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

Have you ever been exposed to or infected with: Gonorrhea Hepatitis Syphilis HIV No, I have not

FAMILY HISTORY

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

Ocular Disease / Condition				Relationship to you
Blindness	Yes	No	Not Sure	_____
Cataract	Yes	No	Not Sure	_____
Crossed Eyes	Yes	No	Not Sure	_____
Glaucoma	Yes	No	Not Sure	_____
Macular Degeneration	Yes	No	Not Sure	_____
Retinal Detachment/Disease	Yes	No	Not Sure	_____
Systemic Disease / Condition				
Arthritis	Yes	No	Not Sure	_____
Cancer	Yes	No	Not Sure	_____
Diabetes	Yes	No	Not Sure	_____
Heart Disease	Yes	No	Not Sure	_____
High Blood Pressure	Yes	No	Not Sure	_____
Kidney Disease	Yes	No	Not Sure	_____
Lupus	Yes	No	Not Sure	_____
Thyroid Disease	Yes	No	Not Sure	_____
Other				_____

MEDICAL HISTORY

Date of your last eye exam_____ Who performed the exam?_____

Do you wear glasses? Y N How old is your present pair of glasses?_____

Do you wear contact lenses? Y N How old is your present pair of contacts?_____

If you are not a contact lens wearer, are you interested in contacts? Y N

Name of Medical Doctor and/or Practice _____

Address and Phone #_____

Do you have any allergies to medications? Y N If yes, Explain:_____

List any medications you take (including oral contraceptives, aspirin, and over the counter medications):

List all major injuries, surgeries and/or hospitalizations 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 or nursing? Y N

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

SYSTEM:							
Cancer	Yes	No	Not Sure	**Ears, Nose, Mouth, Throat**			
Constitutional				Allergies/Hay Fever	Yes	No	Not Sure
Fever, Weight Loss/Gain	Yes	No	Not Sure	Sinus Congestion	Yes	No	Not Sure
Integumentary (Skin)	Yes	No	Not Sure	Runny Nose	Yes	No	Not Sure
Neurological	Yes	No	Not Sure	Post-Nasal Drip	Yes	No	Not Sure
Headaches	Yes	No	Not Sure	Chronic Cough	Yes	No	Not Sure
Migraines	Yes	No	Not Sure	Dry Throat/Mouth	Yes	No	Not Sure
Seizures	Yes	No	Not Sure	**Respiratory**			
Eyes				Asthma	Yes	No	Not Sure
Loss of Vision	Yes	No	Not Sure	Chronic Bronchitis	Yes	No	Not Sure
Blurred Vision	Yes	No	Not Sure	Emphysema	Yes	No	Not Sure
Distorted Vision/Halos	Yes	No	Not Sure	**Vascular/Cardiovascular**			
Loss of Side Vision	Yes	No	Not Sure	Diabetes	Yes	No	Not Sure
Double Vision	Yes	No	Not Sure	Heart Pain	Yes	No	Not Sure
Dryness	Yes	No	Not Sure	High Blood Pressure	Yes	No	Not Sure
Mucous Discharge	Yes	No	Not Sure	Vascular Disease	Yes	No	Not Sure
Redness	Yes	No	Not Sure	**Gastrointestinal**			
Sandy or Gritty Feeling	Yes	No	Not Sure	Diarrhea/Constipation	Yes	No	Not Sure
Itching/Burning	Yes	No	Not Sure	**Genitourinary**			
Foreign Body Sensation	Yes	No	Not Sure	Genitals/Kidney/Bladd	Yes	No	Not Sure
Excess Tearing/Watering	Yes	No	Not Sure	**Bones/Joints/Muscles**			
Glare/Light Sensitivity	Yes	No	Not Sure	Rheumatoid Arthritis	Yes	No	Not Sure
Eye Pain or Soreness	Yes	No	Not Sure	Muscle Pain	Yes	No	Not Sure
Chronic Infection of Eye or Lid	Yes	No	Not Sure	Joint Pain	Yes	No	Not Sure
Sties or Chalazion	Yes	No	Not Sure	**Lymphatic/Hematologic**			
Flashes/Floaters in Vision	Yes	No	Not Sure	Anemia	Yes	No	Not Sure
Tired Eyes	Yes	No	Not Sure	Bleeding Problems	Yes	No	Not Sure
Endocrine				**Allergic/Immunologic**	Yes	No	Not Sure
Thyroid/Other Glands	Yes	No	Not Sure	**Psychiatric**	Yes	No	Not Sure

Lifestyle questionnaire

Do you wear glasses? Yes No If yes, how old is your present pair of glasses?_____
How many pair of glasses do you currently use?_____

Do you perform fine or close-up work?	Yes	No
Are you outdoors all or part of the time?	Yes	No
Are you sensitive in bright sunlight?	Yes	No
Do you have trouble reading signs when driving at nig	Yes	No
Oncoming headlights at night?	Yes	No
Are you bothered by glare from: Overhead lighting?	Yes	No
A computer screen?	Yes	No
Is safety protection a concern at work?	Yes	No

The following questions pertain to binocular visual performance (using the eyes together), Please check any of the items which you have experienced.

Fatigue with reading or comprehension drops with time	Yes	No
Confuses similar words or letters	Yes	No
Short attention span	Yes	No
Difficulty keeping place while reading, uses finger as marker	Yes	No
Skips or rereads lines; omits words	Yes	No
Avoids reading or close work	Yes	No
Reverses words or letters	Yes	No
Difficulty remembering what has been read	Yes	No
Poor eye-hand coordination, including poor writing	Yes	No
Nervousness, irritability, or restlessness after maintaining visual concentration	Yes	No
Do you ever see objects double?	Yes	No
Do letters and lines "run together" or words "jump"?	Yes	No

We are committed to providing you the best possible eye care. We realize health care costs are a concern for all patients. Therefore, at Eye Center of Lancaster County, we have developed financial policies that work for you. We provide special discounts for Senior Citizens and Union members. We are happy to help you process your insurance claim forms. However, in order for you to achieve the best benefits, we need your assistance and understanding of our payment policies.

We appreciate payment in full when services are rendered and materials are ordered. We accept cash, personal checks, Visa, Master Card, American Express or Discover. Checks returned due to insufficient funds are subject to a $20.00 processing fee. Exceptions will always be considered when special arrangements are made in advance.

If you have vision insurance, we are eager to help you receive your maximum allowable benefits. In order to help you achieve this, you must provide a COMPLETED insurance form at each office visit. We also request that you realize the following.

1. Your insurance is a contract between you and your insurance carrier. Eye Center of Lancaster County is not a party to that contract.
2. Most insurances do not cover all materials and will not pay the full fees. We expect payment for materials at the time the order is placed. It is your responsibility to submit proper forms for reimbursement. Our office can assist you in understanding your claim form.
3. Some professional services are not covered by vision insurances. However, other services may be covered by your major medical coverage.
4. As a service to our patients, we accept assignment on several insurances (i.e. Medicare, Blue Shield, Vision Service Plan, National Vision Administrators, Health America, Medical Assistance, and others, subject to change.).

This means we accept the insurance payment for approved services as payment in full. Please remember, some professional services and specialty material items may not be approved by your specific insurance plan.

We must emphasize that as vision-care providers, our relationship is with you, not the insurance company. While our office participates with Medicare and many other programs, all charges are ultimately your responsibility. If temporary financial problems arise, we encourage you to promptly contact our office.

If you have any questions regarding insurance coverage, please do not hesitate to speak to our business manager. We are always here to help you.

Photographs of the Retina are part of the level of care which our office provides to our patients. These photographs are taken for all new patients and for certain medical conditions. There is an additional charge for this service.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for any professional services rendered. I have read all the information on this sheet. I will notify you of any changes in my health status or any other information should the need arise.

I request that payment of authorized insurance benefits be made either to me or on my behalf to Eye Center of Lancaster County for any services furnished me by that physician/supplier.

I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents and/or to any Medigap Insurer any information needed to determine the benefits payable for related services.

I permit a copy of this authorization to be used in place of the original.

Signature_____Date_____