Patient History Questionnaire

Date_____

Last: _____ First:_____ MI ____ Nickname_____

Address_____ DOB ___/___/____ SSN ___-___-_____

_____ Birth Sex F M Decline to specify

City _____ State____ Zip _____ Email _____

Cell _____-_____-_____ Work _____-_____-_____ Home _____-_____-_____

Occupation _____ Computer Usage_____

Special Needs_____ Sports/Hobbies_____

Parent/guardian_____ Family Doctor _____

Last Eye Exam_____ Dr. Phone _____-_____-_____

Last Medical Exam _____ Alt. Contact _____ Phone _____-_____-_____

Note: For dates where exact date is unknown, please use a number that is as close as you can remember.

Only check Yes to those items you are experiencing or think you might be.
You don't NEED to check NO!

Review of Systems

CONSTITUTIONAL

Fever	___ Y	___ N	___ ?
Weight gain/loss	___ Y	___ N	___ ?

INTEGUMENTARY

Skin	___ Y	___ N	___ ?

NEUROLOGICAL

Headaches	___ Y	___ N	___ ?
Migraines	___ Y	___ N	___ ?
Seizures	___ Y	___ N	___ ?

EARS/ NOSE/ THROAT

Allergies/ hay fever	___ Y	___ N	___ ?
Sinus congestion	___ Y	___ N	___ ?
Runny nose	___ Y	___ N	___ ?
Post-nasal drip	___ Y	___ N	___ ?
Chronic cough	___ Y	___ N	___ ?
Dry throat/mouth	___ Y	___ N	___ ?
Ringing in ears	___ Y	___ N	___ ?
Ear pain or infection	___ Y	___ N	___ ?
Hearing aids	___ Y	___ N	___ ?
Deaf	___ Y	___ N	___ ?

GASTROINTESTINAL

Diarrhea	___ Y	___ N	___ ?
Constipation	___ Y	___ N	___ ?

EYES

Loss of vision	___ Y	___ N	___ ?
Blurred vision	___ Y	___ N	___ ?
Distorted vision/halos	___ Y	___ N	___ ?
Loss of side vision	___ Y	___ N	___ ?
Double vision	___ Y	___ N	___ ?
Dryness	___ Y	___ N	___ ?
Mucous discharge	___ Y	___ N	___ ?
Redness	___ Y	___ N	___ ?
Itching	___ Y	___ N	___ ?
Burning	___ Y	___ N	___ ?
Foreign body sensation	___ Y	___ N	___ ?
Excess tearing	___ Y	___ N	___ ?
Glare/light sensitivity	___ Y	___ N	___ ?
Eye pain/soreness	___ Y	___ N	___ ?
Chronic infection eye/lid	___ Y	___ N	___ ?
Styes or chalazion	___ Y	___ N	___ ?
Flashing lights	___ Y	___ N	___ ?
Floaters in vision	___ Y	___ N	___ ?
Tired eyes	___ Y	___ N	___ ?
Color blind	___ Y	___ N	___ ?

VASULAR/CARDIOVASCULAR

Diabetes ___ Y ___ N ___ ?
Heart disease ___ Y ___ N ___ ?
High blood pressure ___ Y ___ N ___ ?
High cholesterol ___ Y ___ N ___ ?

GENITOURINARY ___ Y ___ N ___ ?

Gonads/Kidneys/Bladder ___ Y ___ N ___ ?

LYMPHATIC/HEMATOLOGICAL

Anemia ___ Y ___ N ___ ?
Bleeding problems ___ Y ___ N ___ ?

BONES/JOINTS/MUSCLES

Rhemumatoid arthritis ___ Y ___ N ___ ?
Other arthritis ___ Y ___ N ___ ?
Muscle pain ___ Y ___ N ___ ?
Joint pain ___ Y ___ N ___ ?

ENDOCRINE

Thyroid/other glands ___ Y ___ N ___ ?

PSYCHIATRIC ___ Y ___ N ___ ?

ALLERGIC/IMMUNOL(___ Y ___ N ___ ?

If you answered * ? * 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 follwing conditions

DISEASE/CONDITIONS		RELATIONSHIP
Blindness	___ Y ___ N ___ ?	_____
Cataracts	___ Y ___ N ___ ?	_____
Glaucoma	___ Y ___ N ___ ?	_____
Crossed eyes	___ Y ___ N ___ ?	_____
Macular degeneration	___ Y ___ N ___ ?	_____
Retinal detachment/disease	___ Y ___ N ___ ?	_____
Arthritis	___ Y ___ N ___ ?	_____
Cancer	___ Y ___ N ___ ?	_____
Diabetes	___ Y ___ N ___ ?	_____
Heart disease	___ Y ___ N ___ ?	_____
High blood pressure	___ Y ___ N ___ ?	_____
High cholesterol	___ Y ___ N ___ ?	_____
Kidney disease	___ Y ___ N ___ ?	_____
Lupus	___ Y ___ N ___ ?	_____
Thyroid disease	___ Y ___ N ___ ?	_____
Asthma	___ Y ___ N ___ ?	_____
Other	___ Y ___ N ___ ?	_____

If other , explain _____

MEDICAL HISTORY

Do you have any allergies to medication? ___YES ___NO

If yes, Explain _____

List any medication you take (including oral conterceptives, asprin, over the counter medication & home remedies

List all major injuries, surgeries and/or hospitalization you have had:

List any of the following that you have had:

Prominent eyes	___ Y ___ N	Eye injury	___ Y ___ N
Eye infection	___ Y ___ N	Lazy eye	___ Y ___ N
Cataracts	___ Y ___ N	Glaucoma	___ Y ___ N
Crossed eyes	___ Y ___ N	Drooping eyes	___ Y ___ N
Retinal disease	___ Y ___ N		

Do you wear glasses ___ Y ___ N If yes, how old is your present pair of glasses? _____ Years

Do you wear contacts ___ Y ___ N If yes, how old is your present pair of lenses? _____ Weeks

Type of contact Lenses: ___ Rigid ___ Soft ___Extended wear ___Dailies ___Other

Are they confortable ? ___ Y ___ N

Are you pregnant? ___ Y ___ N

SOCIAL HISTORY

This information is kept strictly confidential. However you may dicuss this portion directly with the doctor.

____YES I would prefer to discuss my social history information directly with my doctor.

Do you Drive? ___YES ___NO If yes, do you have any visual diffculty when driving? ___YES___NO

If yes, please describe _____

DO YOU USE:

Tobacco products ? ___ Y ___ N If yes, type/amount/how long?

_____

Alcohol? ___ Y ___ N If yes, type/amount/how long?

_____

Illegal drugs? ___ Y ___ N If yes, type/amount/how long?

_____

Have you ever been exposed to or infected with :

Gonorrhea	__y ___ N __?	Hepatitis	__y ___ N __?
Syphillis	__y ___ N __?	HIV/AIDS	__y ___ N __?

By completeing this form you are agreeing with our communication services. The company can provide services and communicate with me via phone, text message sms, email and any other kind of online communication, provided that the communication is compliant with current Privacy Regulations and will not be shared with third parties.

Whom may we thank for referring you ?

_____

Routine vs. Medical Exams

For insurance purposes, eye examinations are divided into two categories:

Routine Vision Exams: These are exams for people who have **no eye disease or chronic medical conditions (red, itchy, watery, dry, etc.)** Your eyes will be examined for any needed correction (eyeglasses or contacts). If your doctor indicates, further testing of a medical nature may be needed and would be billed through your medical insurance.

Medical Eye Exams: These are comprehensive exams for the diagnosis and treatment of ophthalmic and systemic diseases. Some examples of conditions evaluated during a medical eye exam are **diabetic retinopathy, cataracts, glaucoma, dry eyes, etc.**

Please choose one of the following:

☐ I choose to use my Routine vision coverage. I wish to be evaluated for any needed correction of my vision for glasses or contacts.

I understand that I may need further evaluation or testing of a medical nature. If Dr. Bomse finds its necessary we may need to bill through your medical insurance and/or have you return for a separate visit.

☐ I choose to use my medical insurance.

Patient
Signature_____Date:_____

FAMILY

HIPAA Acknowledgement Form

DATE_____

Patient Name _____

Relationship to the patient _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly

-Obtain payment from designated third-party payers.

-Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been given the right to review the practices Notice of Privacy Practices (NOPP) prior to signing this consent. I understand that the practice has the right to change its NOPP from time to time and that I may contact the practice at any time to obtain a current copy of the NOPP.

I understand that I may request in writing that the practice restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the practice is not required to agree to my requested restrictions, but if it does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the practice has taken action relying on this consent.

Signature _____