

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/IMMUNOLC 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, aspirin, 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	<input type="checkbox"/> Y <input type="checkbox"/> N	Eye injury	<input type="checkbox"/> Y <input type="checkbox"/> N
Eye infection	<input type="checkbox"/> Y <input type="checkbox"/> N	Lazy eye	<input type="checkbox"/> Y <input type="checkbox"/> N
Cataracts	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N
Crossed eyes	<input type="checkbox"/> Y <input type="checkbox"/> N	Drooping eyes	<input type="checkbox"/> Y <input type="checkbox"/> N
Retinal disease	<input type="checkbox"/> Y <input type="checkbox"/> 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 comfortable? Y N

Are you pregnant? Y N

SOCIAL HISTORY

This information is kept strictly confidential. However you may discuss 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 difficulty when driving? YES NO
If yes, please describe _____

DO YOU USE:

Tobacco products ?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, type/amount/how long? _____
Alcohol?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, type/amount/how long? _____
Illegal drugs?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, type/amount/how long? _____

Have you ever been exposed to or infected with :

Gonorrhea	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?
Syphillis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?	HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> ?

As a current or prospective patient, you understand that you can text STOP at any time to opt out of receiving SMS text messages from us. You can text us HELP at any time to receive Help. Your mobile information will not be shared with any third parties/affiliates for marketing/promotional purposes. All policies are followed as per CTIA guidelines 5.2.1. At any time if you want your information to be removed, you can contact us via familyeyecare727@aol.com.

Whom may we thank for referring you ?

FAMILY EYE CARE

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 practice's 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 _____

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: _____