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 completing this form you are agreeing with our communication services. We can provide services and communicate with you via phone, text msg, sms, email and any other kind of online communication that is compliant with current Privacy Regulations. We do not sell, trade, or otherwise transfer to outside parties your personal identifiable, information. This does not include trusted third parties who assist us in operating our website conducting our business, or servicing you, so long as those parties agree to keep this information confidential.

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:

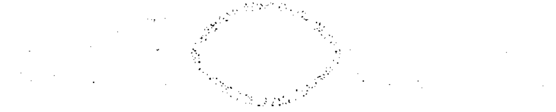
☐ I choose to use my Routine vision coverage. I wish to be evaluated for any needed correction of my vision for glasses or contacts.

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 ____