MEDICAL HISTORY QUESTIONNAIRE

PATIENT INFORMATION

FULL NAME: _____ TODAY'S DATE_____/_____/_____
ADDRESS: _____ PHONE: _____
CITY, STATE ZIPCODE:_____ CELL: _____
BIRTH DATE: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____ SEX: _____MALE _____FEMALE
E-MAIL_____ LAST MEDICAL EXAM: _____ LAST EYE EXAM: _____/_____
PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS *(Please Circle):* Cell Home Phone Email Text Message
MEDICAL DOCTOR:_____ PREVIOUS EYE DR._____
MARITAL STATUS: _____ SPOUSE'S NAME_____
NAMES OF CHILDREN IN LIVING IN YOUR HOUSEHOLD_____
OCCUPATION:_____ ___FULL TIME___PART TIME___RETIRED ___STUDENT SCHOOL:_____
EMPLOYER:_____ WORK PHONE:_____
VISION INSURANCE_____ PRIMARY MEDICAL INSURANCE_____
HOW DID YOU HEAR ABOUT OUR OFFICE? (Please Circle) Insurance website Google Yahoo Walk By Yellow Pages Referral
*WHO MAY WE THANK FOR REFERRING YOU?*_____

INSURED PARTY INFORMATION (if it is yourself; continue to next section)

INSURED NAME: _____ RELATIONSHIP TO PT._____
INSURED ADDRESS: _____ PHONE:_____ BIRTH DATE:___/___/___(insured)
EMPLOYER:_____ WORK PHONE:_____
EMPLOYER ADDRESS:_____

MEDICAL HISTORY

List any medications you take (including oral contraceptives, aspirin, over the counter medications and vitamins):_____
_____
Do you have any environmental allergies or allergies to medications? ___YES___NO If yes, please explain: _____
_____
List all major injuries, surgeries and/or hospitalizations:_____
_____
List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infection or eye injury:_____
Do you wear glasses? ____YES ____NO If yes, how old is your present pair?_____
Do you wear contacts? ____YES ____NO If yes, what type do you wear?_____

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	□	□	_____
Cancer	□	□	_____
Diabetes	□	□	_____
Heart Disease	□	□	_____
High Blood Pressure	□	□	_____
Autoimmune Disease	□	□	_____
Thyroid Disease	□	□	_____
Other _____	□	□	_____

Please turn over and complete the other side

SOCIAL HISTORY

Do you drive? □ no □ yes If yes, do you have a visual difficulty when driving? □ no □ yes If yes, please describe:
_____

Do you use tobacco products? □ no □ yes If yes, what type? Amount? How many years? _____
Do you drink alcohol? □ no □ yes If yes, what type? Amount? How many years? _____
Do you use illegal drugs? □ no □ yes If yes, what type? Amount? How many years? _____

REVIEW OF SYSTEMS

Do you currently or have any problems in the following areas:

SYSTEM	NO	YES	?	SYSTEM	NO	YES	?
CONSTITUTIONAL				**EARS, NOSE, MOUTH, THROAT**			
Fever, Weight Loss/Gain	□	□	□	Allergies/Hay Fever	□	□	□
INTEGUMENTARY (Skin)	□	□	□	Sinus Congestion	□	□	□
NEUROLOGICAL				Runny Nose	□	□	□
Headaches	□	□	□	Post Nasal Drip	□	□	□
Migraines	□	□	□	Chronic Cough	□	□	□
Seizures	□	□	□	Dry Throat/Mouth	□	□	□
EYES RESPIRATORY							
Loss of Vision	□	□	□	Asthma	□	□	□
Blurred Vision	□	□	□	Chronic Bronchitis	□	□	□
Distorted Vision/Halos	□	□	□	Emphysema	□	□	□
Loss of Side Vision	□	□	□	**VASCULAR / CARDIOVASCULAR**			
Double Vision	□	□	□	Diabetes	□	□	□
Dryness	□	□	□	Heart Pain	□	□	□
Mucous Discharge	□	□	□	High Blood Pressure	□	□	□
Redness	□	□	□	Vascular Disease	□	□	□
Sandy or Gritty Feeling	□	□	□	**GASTROINTESTIONAL**			
Itching	□	□	□	Diarrhea	□	□	□
Burning	□	□	□	Constipation	□	□	□
Foreign Body Sensation	□	□	□	**GENITOURINARY**			
Excess Tearing/Watering	□	□	□	Kidney/Bladder	□	□	□
Glare/Light Sensitivity	□	□	□	**BONES / JOINTS / MUSCLES**			
Eye Pain/Soreness	□	□	□	Rheumatoid Arthritis	□	□	□
Chronic Infection of Eye or Lid	□	□	□	Osteoarthritis	□	□	□
Chronic Stye/Chalazion	□	□	□	Muscle/Joint Pain	□	□	□
Flashes/Floaters in Vision	□	□	□	**LYMPHATIC / HEMATOLOGIC**			
Tired Eyes	□	□	□	Anemia	□	□	□
ENDOCRINE				Bleeding Problems	□	□	□
Thyroid Dysfunction	□	□	□	**ALLERGIC / IMMUNOLOGIC**	□	□	□
Other Gland Dysfunction	□	□	□	**PSYCHIATRIC**	□	□	□

If you answered YES to any of the above or have a condition not listed, please explain:

_____
_____
_____
_____
_____

NOTICE OF PATIENT PRIVACY RIGHTS, PROTECTION, AND RESPONSIBILITIES

SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION

As a member of a vision care program, I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me if my vision insurance carrier denies or does not cover my claim for these services.

MEDICAL NECESSITY

If my insurance determines that a medical service and/or material are not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material stated below.

COPAY's

I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-payments cannot be waived at any time by the provider of service or College Park Eye Care.

DEDUCTIBLES

If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider. Yearly deductibles cannot be waived at any time by College Park Eye Care.

PROFESSIONAL SERVICES AND MATERIALS

I understand that I am responsible for 100% of all professional fees rendered on the date of service. I understand that I am also required to make payment for at least 50% of materials at the time materials are ordered. If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold College Park Eye Care or my insurance carrier responsible for accidental laboratory breakage. If I do not pick up my materials within 60 days from my initial order, my materials will be returned to the laboratory, and my initial deposit will not be refunded. If I am to receive contact lenses by mail, I understand that I am required to pay in full at time of service.

Our Patient Satisfaction Guarantee applies to single vision and progressive lenses. We use only premium single vision optics and premium progressive addition lenses, otherwise known as no line bifocals. Less than one percent of our patients have difficulty adapting to our premium progressive lenses. We will remake a non-adapt progressive lens or single vision lenses one time, in the same frame. If it is still unsatisfactory, we will replace it with a lined bifocal or a single vision lens, in the same frame. While we make every attempt to solve these rare issues, no refunds will be given in a case where a patient does not adapt to a progressive lens or single vision lens.

HIPAA

I understand that under the Health Insurance Probability ACT of 1996 (HIPAA), which I have been provided a copy, that 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 among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operation such as quality assessments and physician certifications.

AGREEMENT

_____	_____	_____
Date of Signing	Guarantor/Patient Signature	Witness

_____
Print Name