



Medical History Questionnaire

Name: _____ Today's Date: ____ / ____ / ____

Birthdate: ____ / ____ / ____ Occupation: _____ Last Eye Exam: _____

Name of primary physician/practice: _____ Last Medical Exam: _____

How were you referred to us? _____

What brings you in to see us today? (circle all that apply)

Glasses / Contacts / Diabetic exam / Driver's License / Cataract / Glaucoma / Eye Pain / Red Eye / Other: _____

Medical History

Do you have any **allergies** to medications? no yes _____ Are you pregnant or nursing? no yes

List **ALL MEDICATIONS** you take (include eye drops, oral contraceptives, aspirin, over-the-counter and vitamins):

List all major injuries, surgeries (including the eye) and/or hospitalizations you have had: _____

On average, how many hours daily do you use a computer and mobile devices? _____

Do you wear glasses? no yes If yes, how old is your current prescription? _____

Do you wear contacts? no yes If yes, list brand name & power _____

Are they comfortable? always usually sometimes rarely never

Do you sleep in your contacts? always usually sometimes rarely never

What contact solution do you use? _____

How often do you replace your contacts? _____

Are you interested in trying better contact lenses? yes no maybe

Family History

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

| DISEASE / CONDITION | NO | YES | ? | RELATIONSHIP TO YOU |
|------------------------------|--------------------------|--------------------------|--------------------------|---------------------|
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Crossed Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Retinal Detachment / Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Social History

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes

Do you use tobacco products? no yes If yes, list type, amount & how long _____

Do you drink alcohol? no yes If yes, list type, amount & how frequently _____

Do you use illegal drugs? no yes If yes, list type, amount & how frequently _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you have any problems in the following areas?

GENERAL HEALTH

Fever / Chills no yes

Weight Loss / Gain no yes

SKIN

Dry skin / Eczema no yes

Oily skin / Acne no yes

NEUROLOGICAL

Headaches no yes

Migraines no yes

Seizures no yes

Developmental/Learning no yes

EYES

Blurred Vision no yes

Glare or Halos no yes

Tired Eyes no yes

Flashes / Floaters no yes

Loss of Side Vision no yes

Double Vision no yes

Dryness no yes

Mucous Discharge no yes

Redness no yes

Sandy or Gritty Feeling no yes

Itching no yes

Burning no yes

Foreign Body Sensation no yes

Excess Tearing / Watering no yes

Light Sensitivity no yes

Eye Pain or Soreness no yes

Chronic Infection no yes

Sties or Chalazion no yes

ALLERGIC / IMMUNOLOGIC

Seasonal Allergies no yes

Environmental Allergies no yes

Autoimmune disorder no yes

Other: _____

EARS, NOSE, MOUTH & THROAT

Dry Throat / Mouth no yes

Sinus Congestion no yes

Runny Nose no yes

ENDOCRINE

Diabetes no yes

Thyroid / Other no yes

RESPIRATORY

Asthma no yes

COPD no yes

Lung Cancer no yes

CARDIOVASCULAR

High Blood Pressure no yes

Elevated Cholesterol no yes

Vascular Disease no yes

Heart Pain / Angina no yes

GASTROINTESTINAL

Constipation no yes

Diarrhea no yes

GENITOURINARY

Prostate Enlargement/Cancer no yes

ED no yes

Breast Cancer no yes

Uterine or Ovarian no yes

Kidney/Bladder Infections no yes

BONES, JOINTS & MUSCLES

Muscle Pain no yes

Osteoarthritis no yes

Rheumatoid Arthritis no yes

LYMPHATIC & HEMATOLOGIC

Bleeding Problems no yes

Anemia no yes

PSYCHIATRIC (please circle)

ADD/ADHD/Hyperactivity no yes

Personality Disorder no yes

Anxiety or Depression no yes

Thank you for your honesty. It helps us take better care of you!

(For Staff Use ONLY)

Dr. /Tech _____

Date _____



Palmetto Eyecare Associates, P.A.

PATIENT INFORMATION

Patient: First _____ MI _____ Last _____

Street Address: _____ Apt. No. _____

City: _____ State: _____ Zip Code: _____ Sex: M F

Home Phone: _____ Cell Phone: _____ Email: _____

DOB: _____ SS#: _____ Single Married Divorced Widowed

Employed FT/PT Student Retired Other Patient's Employer: _____

Race: Caucasian African American Hispanic Asian Indian

Ethnicity: Not Hispanic/Latino Hispanic/Latino Pacific Islander

Guardian/Responsible Party (If Applicable): _____

MEDICAL INSURANCE INFORMATION

Insured Name: _____ Relationship to Patient: _____

Insured Date of Birth: _____ Insured Social Security # _____

Insurance Co. Name/Address: _____

Identification Number: _____ Group Number: _____ Employer: _____

VISION INSURANCE INFORMATION

Insured Name: _____ Relationship to Patient: _____

Insured Date of Birth: _____ Insured Social Security # _____

Insurance Co. Name/Address: _____

Identification Number: _____ Group Number: _____ Employer: _____

FINANCIAL RESPONSIBILITY (INSURANCE)

I hereby authorize payment directly to Palmetto Eyecare Associates, P.A. for benefits otherwise payable to me for services. I accept responsibility for the balance of fees not paid by insurance.

Signature of Patient or Guardian

Date

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)
 2. Medical insurance (such as Blue Cross/Blue Shield and Medicare).
- Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
 - Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
 - If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
 - We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

Acknowledgement of Receipt of Notice of Privacy Practices (effective 09/17/2013)

I have been informed and given the right to review and secure a copy of the *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Palmetto Eyecare Associates, P.A. reserves the right to change the terms of this notice from time to time and that I may contact Palmetto Eyecare Associates, P.A. at any time to obtain the most current copy of this notice.

Signature

Date