Please fill out entire form. Thanks!

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	□	□	□	_____
Cataracts	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment / Disease	□	□	□	_____
Arthritis	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Thyroid Disease	□	□	□	_____
Other _____	□	□	□	_____

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

*****PLEASE SIGN HIPAA FORM ON THE BACK*****

Palmetto Eyecare Associates, P.A.

Vision Insurance vs Medical 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.
- **We will bill your Medical Insurance plan for any additional testing not part of your routine exam. Some of these tests include Fundus Photos, OCT, Visual Field, Pachymetry, Gonioscopy and Topography. If fees are not paid by your plan, we will bill you for any unpaid deductible, copay or coinsurance allowed by your insurance contract.**
- 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 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.

I have been informed about the difference between vision and medical plan benefits.

_____ _____

Signature **Date**

Acknowledgment 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**