MEDICAL HISTORY QUESTIONNAIRE

PATIENT INFORMATION: (PLEASE PRINT)

SEX ☐ MALE ☐ FEMALE

LAST NAME _____ DATE OF BIRTH _____

FIRST NAME _____ MI ___ SOCIAL SECURITY _____

ADDRESS _____ MARITAL STATUS ☐ DIVORCED

☐ LEGALLY SEPARATED

_____ ☐ MARRIED

☐ SINGLE

CITY _____ ☐ WIDOWED

STATE _____ ZIP _____ EMPLOYMENT STATUS ☐ EMPLOYED FULL TIME

☐ EMPLOYED PART TIME

HOME PHONE _____ ☐ STUDENT FULL TIME

☐ STUDENT PART TIME

DAYTIME PHONE _____ ☐ NOT EMPLOYED

PRIMARY INSURANCE _____ EMPLOYER _____

RESPONSIBLE PARTY: ☐ SELF

LAST NAME _____ SEX ☐ MALE ☐ FEMALE

FIRST NAME _____ MI ___ DATE OF BIRTH _____

ADDRESS _____ SOCIAL SECURITY _____

_____ HOME PHONE _____

CITY _____ DAYTIME PHONE _____

STATE _____ ZIP _____ EMPLOYER _____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite Medicare / Insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. Payment is due when services are rendered unless other arrangements have been made in advance.

I understand that if this is not filled out in its entirety, Vision Care Associates will not submit charges to my insurance carrier and that any inaccuracies will cause denial of benefits and/or delays in payment.

I hereby authorize VISION CARE ASSOCIATES to furnish to Medicare/Insurance Carriers any information needed to determine benefits payable for services rendered to myself or my dependants. I authorize that payment of these benefits be made on my behalf to Vision Care Associates. I understand that I am responsible for any amount not covered under Medicare/Insurance.

Accounts not paid within 60 days of date of service are subject to a $25 late fee and will accrue interest at a monthly rate of 1.5% (18% annual rate of interest). Checks returned not paid are also subject to a $25 fee.

I acknowledge that I have been offered a Statement of Privacy Practices.

Signature _____ Date _____

PLEASE TURN PAGE OVER

SOCIAL HISTORY: *This information is kept strictly confidential. If you prefer to discuss this with your doctor, leave blank.*

Do you use tobacco products? ☐ No ☐ Yes If yes, kind/amount/how long? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, kind/amount/how long? _____

Medical Doctor/Clinic: _____ Pharmacy: _____

PERSONAL MEDICAL HISTORY:

Do you have any allergies to medications? ☐ No ☐ Yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

List eye medications: _____

Are you pregnant or nursing? ☐ No ☐ Yes

REVIEW OF SYSTEMS: *Do you currently have, or have you ever had, any problems in the following areas?*

	NO	YES		NO	YES
CONSTITUTIONAL			**RESPIRATORY**		
FEVER/WEIGHT GAIN	☐	☐	ASTHMA	☐	☐
INTEGUMENTARY			EMPHYSEMA	☐	☐
SKIN	☐	☐	**VASCULAR/CARDIOVASCULAR**		
NEUROLOGICAL			HEART/VASCULAR DISEASE	☐	☐
HEADACHES	☐	☐	HIGH BLOOD PRESSURE	☐	☐
EARS/NOSE/MOUTH/THROAT			**GASTROINTESTINAL**		
CONGESTION	☐	☐	STOMACH	☐	☐
CHRONIC COUGH	☐	☐	**GENITOURINARY**		
EYES			KIDNEY/BLADDER	☐	☐
CATARACTS	☐	☐	**BONES/JOINTS/MUSCLES**		
GLAUCOMA	☐	☐	JOINT PAIN/ARTHRITIS	☐	☐
LAZY EYE	☐	☐	**LYMPHATIC/HEMATOLOGIC**		
MACULAR DEGENERATION	☐	☐	BLEEDING PROBLEMS	☐	☐
DRY EYE	☐	☐	**PSYCHIATRIC**		
CROSSED EYES	☐	☐	DEPRESSION	☐	☐
ALLERGIC/IMMUNOLOGIC			**ENDOCRINE**		
SEASONAL ALLERGIES/HAY FEVER	☐	☐	DIABETES	☐	☐
ENVIRONMENTAL ALLERGIES	☐	☐	THYROID/OTHER GLANDS	☐	☐

OCULAR SURGERIES:

	LEFT EYE	RIGHT EYE	DATE OF SURGERY
LASIK	☐	☐	_____
CATARACTS	☐	☐	_____
MACULAR DEGENERATION	☐	☐	_____
RETINAL DETACHMENT	☐	☐	_____
OTHER	☐	☐	_____

FAMILY HISTORY: Please note any family history (Parents, Grandparents, siblings, children, or deceased)

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
BLINDNESS	☐	☐	_____
GLAUCOMA	☐	☐	_____
MACULAR DEGENERATION	☐	☐	_____
DIABETES	☐	☐	_____
HIGH BLOOD PRESSURE	☐	☐	_____