

Medical History Questionnaire

Patient Information:

Last Name _____

First Name _____ MI _____

Mailing Address _____

City _____

State _____ Zip _____

Home Phone _____

Daytime Phone _____

Cell Phone _____

E-Mail Address _____

Medicare Number _____

Primary Insurance _____

Sex Male Female

Date of Birth _____

Social Security _____

Marital Status Divorced

Married Legally Separated

Single Widowed

Employment Employed Full Time

Student Full Time Employed Part Time

Student Part Time Not Employed

Employer _____

Occupation _____

Race Other American Indian

White Black or African American

Asian Native Hawaiian/Pacific Islander

Ethnicity Other Hispanic/Latino

Responsible Party: (If other than self)

Last Name _____

First Name _____

Address _____

City _____

State _____ Zip _____

Sex Male Female

Date of Birth _____

Social Security _____

Home Phone _____

Daytime Phone _____

Cell Phone _____

Employer _____

Social History:

Smoking

Current Everyday Smoker Former Smoker

Current Some Day Smoker Never Smoker

Alcohol

None Less than 1/day

1-2/day 3 or more/day

Personal Medical History:

Medication Allergies No Yes

If yes, List Allergy and Reaction _____

If female, are you pregnant or nursing No Yes

I understand that as a part of my electronic health record, Vision Care Associates will transmit my prescriptions electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, Vision Care Associates will obtain the history of all of my past prescriptions dating back two years from the pharmacy benefit manager and I understand that those prescriptions will become a part of my electronic health record. By signing below I hereby give consent to the above action.

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 dependents. 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 complete back side if you are a new patient to Vision Care or haven't been here for three years.

Medical History: Do you currently have, or have you ever had, any of the following:

Anxiety	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Renal Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Osteoarthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Acid Reflux	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Rheumatoid Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hearing Loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Irregular Heartbeat	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hypertension	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bone Marrow Transplant	<input type="checkbox"/> No	<input type="checkbox"/> Yes	HIV/Aids	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Prostate Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	High Cholesterol	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Breast Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hyperthyroid	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Colon Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hypothyroid	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Lung Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Leukemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Prostate Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Lymphoma	<input type="checkbox"/> No	<input type="checkbox"/> Yes
COPD	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Radiation	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Coronary Artery Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diabetes Type 1	<input type="checkbox"/> No	<input type="checkbox"/> Yes, last HbA 1c _____			
Diabetes Type 2	<input type="checkbox"/> No	<input type="checkbox"/> Yes, last HbA 1c _____			

Ocular History: Do you currently have, or have you ever had, any of the following:

Cataracts	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Lazy Eye	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Dry Eye	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Macular Degeneration	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Eye Injury	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Retinal Tear/Detachment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Eye Turn	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Floater	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Lasik Surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Date of Surgery/Which Eye	_____	
Cataract Surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____	
Corneal Transplant Surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____	
Injections (Diabetic, Mac. Degen.)	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____	
Lid Surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____	
Glaucoma Surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____	
Laser Surgery (Retina, Cataract)	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____	
Eye Turn Surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes		_____	

Family History: (List family history for parents, grandparents, brothers and sisters)

Blindness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Macular Degeneration	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Eye Turn	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Lazy Eye	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Retinal Detachment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Hypertension	<input type="checkbox"/> No	<input type="checkbox"/> Yes

List all Current Medications (include dosage, frequency, how taken, i.e. aspirin 81mg once a day)

List Eye Medications
