Medical History Questionnaire

Name_____ **Email:** _____

Address_____**Apt#**_____ **Cell Phone**_____

City_____**Zip**_____ **Home Phone**_____

SSN#_____/_____/_____ **Birth Date**_____/_____/_____ **AGE** _____ **Gender:** □**M** □**F**

Occupation **Employer/Company** **How did you hear about our office?**

_____ _____ _____

We will need a copy of your Medical Insurance Card for our records

Vision Insurance_____**Member ID# or SSN:** _____

Primary Member Name_____**Member Birthdate:**_____/_____/_____

Medical Insurance_____**Member ID# or SSN:** _____

Primary Member Name_____**Member Birthdate:**_____/_____/_____

Main purpose of today's visit: **DATE of Last Eye Exam** **PLACE of Last Eye Exam**

_____ _____ _____

Do you wear Glasses? □**Y** □**N** **How old are your glasses?**_____**years** **When do you wear your glasses?**_____

Do you wear Contact Lenses? □**Y** □**N** **How often do you dispose of your Contacts?** □**1day** □**2weeks** □**1month** □**3months** □**6months** □**1year**

Do you sleep in your Contacts?□**Y** □**N** **Brand & Power of Contact Lenses**_____**Brand of Cleaning Solution**_____

Are you obtaining, renewing, or updating your contact lens prescription for this year?□**Y** □**N** **Please read and sign below:**

Please Note: Contact Lens Services are Not included in the annual exam fees. The contact lens exam is a separate exam for ensuring proper fit of your contacts and evaluating your vision with the contacts. Additional time and fees will be required and may vary depending on your insurance and prescription needs.

□ **YES** _____ **I would like to be examined for contact lenses today, I understand that I will be assessed a contact lens evaluation fee ($29 -$129)**

□ **NO**_____**I do not want a prescription for contact lenses. I do not want to be evaluated for contact lenses.**

Are you CURRENTLY experiencing any of these symptoms related to the eyes? *(Please check all that applies)*

□Blurred Distance Vision	□Redness	□Floating spots/Flashes of light
□Blurred Intermediate Vision	□Double Vision	□Light sensitivity
□Blurred Near Vision	□Irritated eyes	□Night time Glare or Haloes
□Headaches	□Dryness	□Computer Glare
□Mucous Discharge	□Sandy / Gritty Eyes	□ Sties or bumps on eyelids
□Sore or Tired eyes (Eyestrain)	□Tearing/Watering	□Discomfort with Contact Lenses
□Eye Pain	□Foreign Body Sensation	□Eyelashes matted shut in mornings

Have YOU or anyone in your immediate FAMILY (parents, grandparents, siblings) been diagnosed with any of the following?

• Eye Injury	• Cataracts	□Self □Family	• Diabetes	□Self □Family
• Eye Infection	• Glaucoma	□Self □Family	• High Blood Pressure	□Self □Family
• Eye Surgery (LASIK)	• Diabetic Retinopathy	□Self □Family	• High Cholesterol	□Self □Family
• Lazy Eye	• Retinal Detachment	□Self □Family	• Thyroid (Hypo/Hyper)	□Self □Family
• Keratoconus	• Macular Degeneration	□Self □Family	• Arthritis	□Self □Family

Are you taking any MEDICATIONS? □ Yes □ No

List any medications you take (including vitamins, over the counter medications, Aspirin, birth control, home remedies):

_____

_____

Please list any HOBBIES or SPORTS_____

Do you have any allergies to medications? □**Y** □**N** _____ Are you Pregnant or Nursing? □Y □N

Please turn over and fill out BACK Side of Questionnaire Signature Required

Medical History Questionnaire

Review of Systems:
Do you currently, or have you ever had any problems in the following areas. If yes, please explain each condition.

Constitutional:
- Fever, Weight Loss/Gain Y N _____

Integumentary (skin) Y N _____

Neurological
- Headaches Y N _____
- Migraines Y N _____
- Seizures Y N _____

Endocrine
- Thyroid/Other Glands Y N _____

Ears, Nose, Mouth Throat
- Allergies/ Hay Fever Y N _____
- Sinus Congestion Y N _____
- Runny Nose Y N _____
- Post Nasal Drip Y N _____
- Chronic Cough Y N _____
- Dry Throat/ Mouth Y N _____

Psychiatric Y N _____

Allergic / Immunologic Y N _____

Respiratory
- Asthma Y N _____
- Chronic Bronchitis Y N _____
- Emphysema Y N _____

Vascular / Cardiovascular
- Heart Pain Y N _____
- Vascular Disease Y N _____

Gastro-Intestinal
- Diarrhea Y N _____
- Constipation Y N _____

Genitourinary
- Genitals Y N _____
- Kidneys Y N _____
- Bladder Y N _____

Bones / Joints / Muscles
- Rheumatoid Arthritis Y N _____
- Muscle Pain Y N _____
- Joint Pain Y N _____

Lymphatic / Hematologic
- Anemia Y N _____
- Bleeding Problems Y N _____

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

_____

_____

AUTHORIZATION TO RELEASE INFORMATION: I/ WE hereby authorize AccuVision Optometry to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration and Workers Compensation.
CONSENT FOR TREATMENT: I/WE hereby authorize the practice to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment on all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay deductible, co pay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.
HIPPA Privacy Notice: In the course of providing serving you, we create, receive and store protected health care information that identifies you. It is often necessary to use and disclose this health care information for the purposes of treatment, payment, and health care operations involving our office.

Patient Signature_____ **Date:** _____

Doctor Use Only_____

Doctor Signature:_____ Date_____

Reviewed by_____ ☐ No Changes Date_____

Reviewed by_____ ☐ No Changes Date_____

Reviewed by_____ ☐ No Changes Date_____