Medical History Questionnaire

Name: _____ **Today's Date:** ____/____/_____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone #1: _____ **(home/work/cell) Phone #2:** _____ **(home/work/cell)**
Email Address: _____ **Referred By:** _____
Preferred Communication: Email Text Phone Call (please circle one)
Date of Birth: _____/_____/_____ **Male ❑ Female ❑ Social Security Number:** _____/_____/_____

Place of Employment: _____ **Occupation:** _____

Guardian (If Applicable): _____ **Date of Birth:** _____/_____/_____
Relationship to Patient: _____ **Social Security Number:** _____/_____/_____
Address if Different from Patient: _____

Insurance Company: _____ **ID #:** _____
Name of Primary Account Holder: _____ **Date of Birth:** _____/_____/_____
Relationship to Patient: _____ **Social Security Number:** _____/_____/_____
Address if Different from Patient: _____

Medical History

Name of Medical Doctor: _____ **Phone #:** _____
Last Visit: _____ **Date of Last Eye Exam:** _____
Height: ____'____" **Weight:** _____ **lbs. Blood Pressure:** ____/_____ **Pulse:** _____ **Date Taken:** ____/____/_____
Are you pregnant? Yes ❑ No ❑ Nursing? Yes ❑ No ❑
Do you have any allergies to medicine? _____
If yes, explain: _____
List all medications (including oral contraceptives, aspirin, over the counter medications & home remedies):
_____
_____
List all major injuries, surgeries and/or hospitalizations you have had:
_____
Circle any of the following you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, eye infections or eye injury. If injury please explain:
_____
Do you wear glasses: Yes ❑ No ❑ If yes, how old is your present pair of lenses? _____
Do you wear contacts: Yes ❑ No ❑ If yes, how old is your present pair of lenses? _____
Type of contact lenses: ❑Rigid ❑Soft ❑Extended Wear ❑Other Are the comfortable? Yes ❑ No ❑

Family History (continued on back)

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

DISEASE/CONDITION	YES	NO	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	_____
Cataract	❑	❑	❑	_____
Crossed Eye	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment/Disease	❑	❑	❑	_____
Arthritis	❑	❑	❑	_____
Cancer	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
Heart Disease	❑	❑	❑	_____

Family History (continued)

DISEASE/CONDITION	YES	NO	?	RELATIONSHIP TO YOU
High Blood Pressure	❑	❑	❑	_____
Kidney Disease	❑	❑	❑	_____
Lupus	❑	❑	❑	_____
Thyroid Disease	❑	❑	❑	_____
Other	❑	❑	❑	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.

❑Yes, I prefer to discuss my social history directly with the doctor.

Do you drive? ❑Yes ❑No If yes, do you have visual difficulty while driving? ❑Yes ❑No

If yes, please describe: _____

Do you use tobacco products? ❑Yes ❑No If yes, type/amount/how long_____

Do you drink alcohol? ❑Yes ❑No If yes, type/amount/how long_____

Do you use illegal drugs? ❑Yes ❑No If yes, type/amount/how long_____

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

Review of Systems

Do you currently, or have you ever had problems in the following areas?

SYSTEM	YES	NO	?
CONSTITUTIONAL	❑	❑	❑
Fever, Weight Loss/Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL	❑	❑	❑
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES	❑	❑	❑
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision/Halos	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy or Gritty Feeling	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excess Tearing/Watering	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic infections of Eye/Lid	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes or Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE	❑	❑	❑
Thyroid/Other Glands	❑	❑	❑

If yes please explain:

_____

_____

SYSTEM	YES	NO	?
EARS NOSE MOUTH THROAT	❑	❑	❑
Allergies/Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post-Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑
RESPIRATORY	❑	❑	❑
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
VASCULAR/CARDIOVASCULAR	❑	❑	❑
Diabetes	❑	❑	❑
Heart Pain	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL	❑	❑	❑
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENETOURINARY	❑	❑	❑
Genitals/Kidney/Bladder	❑	❑	❑
BONES/JOINTS/MUSCLES	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC/HEMATOLOGIC	❑	❑	❑
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
ALLERGIC/IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

If yes please explain:

_____

_____

Please plan on being at our office for approximately one to one and a half hours depending on what type of exam you are having. Your eyes will be dilated at the time of your exam. Please bring a pair of sunglasses with you, if you do not have a pair, a pair will be provided to you. Also, bring your insurance cards, photo ID and a list of medications you may be taking.

Your exam will consist of a complete dilated eye examination including glaucoma check, refraction for glasses, if needed, a thorough evaluation for any eye disease. The fee for a complete eye exam starts at $98. Some patients require special testing such as retinal photos and may generate additional fees. We do accept many different insurance plans but it is your responsibility to call your insurance company to find out if we are on their list of providers and if a routine eye exam is covered.

For patients who currently wear contact lenses or those interested in contacts, there is an additional charge for the contact exam. We will check the health of the cornea, tear flow and any other problems that may be occurring. Contact lens exams start at $70 and increase depending on your prescription and complexity.

We also offer services such as Corneal Refractive Therapy, Orthokeratology, Lasik evaluations, exams for younger children and hard to fit contacts for people with Keratoconus and corneal transplants. We also provide vision therapy programs and training. We offer a wide selection of designer frames and sunglasses, and the latest technology in lenses and lens coatings.

Thank you for choosing Edgewood Eye Center.

Please initial stating you have read this_____

AUTHORIZATION TO PAY BENEFITS

I hereby authorize payment directly to this office of surgical and/or medical benefits, including major medical insurance, if any, otherwise payable to me for service. I understand that I am financially responsible for all non-covered services. I also authorize a photocopy of my signature to be used if needed by insurance or payment made over the phone.

Signed _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have been given the opportunity to read and receive a copy of Edgewood Eye Centers notice of Privacy Policy.

Print Name_____Sign Name_____Date_____

May we leave test results or instructions on your voicemail if you are not available?

Yes_____ No_____

Please list anyone we have authorization to talk to regarding your care:

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

ATTENTION MEDICARE, TRICARE STANDARD (including Retired Reserve & Young Adult Standard) AND ALL MEDICAL ONLY INSURANCE POLICY PATIENTS:
Medicare, Tricare Standard and all medical only policies do not cover routine eye exams or refractions. You will be responsible for the payment of the refraction the day of the eye exam. The cost is $28. Initial_____