

# Medical History Questionnaire

Name: \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Guardian (If Applicable): \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Email address \_\_\_\_\_ Medical Doctor: \_\_\_\_\_

How did you find our practice?(check one)  friend  family  yellow pages  tv/radio  newspaper  internet  other

## 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 all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_  
 \_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury, Lasik/refractive surgery: \_\_\_\_\_

Are you pregnant and/or nursing?  no  yes

Do you wear glasses  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses?  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of Contact Lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  yes  no

## Family History

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

| DISEASE/CONDITION          | NO                       | YES                      | ?                        | RELATIONSHIP TO YOU |
|----------------------------|--------------------------|--------------------------|--------------------------|---------------------|
| Blindness                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Cataract                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Crossed Eyes               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Glaucoma                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Macular Degeneration       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Retinal Detachment/Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Arthritis                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Cancer                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Diabetes                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Heart Disease              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| High Blood Pressure        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Kidney Disease             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Lupus                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Thyroid Disease            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |
| Other _____                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____               |

*\* Please turn this form over and complete side two \**

# Social History

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

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive?  no  yes If yes, do you have visual difficulty when driving?  no  yes If yes, please describe:

Do you use tobacco products?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Do you use illegal drugs?  no  yes If yes, type/amount/how long: \_\_\_\_\_

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

# Review of Systems

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

| SYSTEM                          | NO                       | YES                      | ?                        |  | NO                               | YES                      | ?                        |
|---------------------------------|--------------------------|--------------------------|--------------------------|--|----------------------------------|--------------------------|--------------------------|
| <b>CONSTITUTIONAL</b>           |                          |                          |                          |  | <b>EARS, NOSE, MOUTH, THROAT</b> |                          |                          |
| Fever, Weight Loss/Gain         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Allergies/Hay Fever              | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>INTEGUMENTARY (Skin)</b>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Sinus Congestion                 | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>NEUROLOGICAL</b>             |                          |                          |                          |  | Runny Nose                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Post-Nasal Drip                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraines                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Chronic Cough                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Dry Throat/Mouth                 | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>EYES</b>                     |                          |                          |                          |  | <b>RESPIRATORY</b>               |                          |                          |
| Loss of Vision                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Asthma                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred Vision                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Chronic Bronchitis               | <input type="checkbox"/> | <input type="checkbox"/> |
| Distorted Vision/Halos          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Emphysema                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of Side Vision             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | <b>VASCULAR / CARDIOVASCULAR</b> |                          |                          |
| Double Vision                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Diabetes                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Dryness                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Heart Pain                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Mucous Discharge                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | High Blood Pressure              | <input type="checkbox"/> | <input type="checkbox"/> |
| Redness                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Vascular Disease                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Sandy or Gritty Feeling         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | <b>GASTROINTESTINAL</b>          |                          |                          |
| Itching                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Diarrhea                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Constipation                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Foreign Body Sensation          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | <b>GENITOURINARY</b>             |                          |                          |
| Excess Tearing/Watering         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Genitals/Kidney/Bladder          | <input type="checkbox"/> | <input type="checkbox"/> |
| Glare/Light Sensitivity         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | <b>BONES / JOINTS / MUSCLES</b>  |                          |                          |
| Eye Pain or Soreness            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Rheumatoid Arthritis             | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic Infection of Eye or Lid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Muscle Pain                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Sties or Chalazion              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Joint Pain                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Flashes/Floaters in Vision      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | <b>LYMPHATIC / HEMATOLOGIC</b>   |                          |                          |
| Tired Eyes                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | Anemia                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>ENDOCRINE</b>                |                          |                          |                          |  | Bleeding Problems                | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid/Other Glands            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | <b>ALLERGIC / IMMUNOLOGIC</b>    | <input type="checkbox"/> | <input type="checkbox"/> |
|                                 |                          |                          |                          |  | <b>PSYCHIATRIC</b>               | <input type="checkbox"/> | <input type="checkbox"/> |

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

Doctor's Signature

Date

## EXAM PLUS EXPLANATION AND CONSENT

We are committed to providing the most comprehensive examinations available. For specific patients (VSP/Kaiser/BlueVision) your wellness eye exam provided under this coverage is only a very basic exam. It does not cover testing that we routinely include for other patients, and improves our standard of care. For a small additional fee we provide this care. It includes retinal imaging, specular microscopy, wave front refraction and scanning laser topography.

### EXAM PLUS RETINAL IMAGING

Retinal imaging enhances our diagnostic capability even when dilated however in many cases dilation is not required. Imaging increases our ability to detect glaucoma associated Drance hemorrhages 4x more often than a dilated retinal exam, is more sensitive at diagnosing the most common form of macular degeneration and is the recommended standard of care for diabetic patients. Images serves as a baseline for future comparisons.

### EXAM PLUS SPECULAR CORNEAL MICROSCOPY

A specular microscope allows 240x corneal endothelium images. This is 5-7 times higher resolution than our best office microscopes. A specular assessment allows us to assess the health of the cornea. Below is a partial list of diagnostic conditions used with the specular microscope.

- Corneal dystrophies, medication toxicity from medications such as methytrexate, amiodarone or chloroquine
- Contact lens induced damage/changes. In fact, all our contact lens patients receive a specular scan. It is the most accurate way to assess the health of the cornea associated with contact lens wear. Contact lens fees (fitting/refitting/assessment) will be adjusted for patients with exam plus to reflect this portion of exam plus.
- Ocular diseases such as glaucoma and systemic diseases such as lupus

### WAVEFRONT REFRACTION AND SCANNING LASER TOPOGRAPHY

Some insurance such as VSP now provide coverage for wave front generated lenses. Our Zeiss wave front aberrometer allows use to provide a customized prescription that not only is more accurate but also reduces high order aberrations. Correcting high order aberrations improves clarity of vision and visual acuity. Topographic mapping of the cornea helps with diagnosis surface disease such as dry eye, irregular astigmatism and keratoconus.

**The Exam Plus fee (includes retinal imaging, wave front refraction, topography and specular microscopy) is \$55.50.** Please indicate your choice below.

I wish to proceed with Exam Plus

Please tell me more

Signature \_\_\_\_\_ date \_\_\_\_\_

## ***Payment Policy***

### **Fees for Professional Services:**

If you have a vision wellness exam such as VSP and your history dictated a medically necessary exam, or during the course of the exam it was apparent to the doctor that your exam involved a medical diagnosis that required management such as monitoring, treatment or additional testing, then these conditions fall outside of the definition of your contracted wellness exam. In these circumstances your medical insurance will be billed.

### **Fees for Eyewear:**

Frame & lens fees are due on the day of ordering. If you have insurance coverage overages and co-pays are due in full prior to ordering. Please review the *Frame and Lens Policy* for details.

### **Fees for Contact Lenses:**

Professional fees and fees for lenses are due in full prior to ordering.

Contact lenses can only be returned for credit. They must be intact, in their original packaging with no marking and returned within 30 days of receipt. Custom orders cannot be returned for credit. Fitting and assessment fees are non-refundable. Medical insurances do not cover the assessment of existing contact lenses or refitting. Wellness vision benefits such as VSP do not cover as part of their basic exam these assessments.

### **Retinal Imaging, Wavefront Topography, Refraction and Specular Microscopy:**

These tests help us to provide a higher standard of care. Retinal imaging, wavefront refraction and topography as well as specular microscopy are included in our comprehensive exam. For vision wellness patients these tests are an additional fee. For Medicare patients these tests are included in the refraction fee except where medically necessary as defined by Medicare.

### **Patients with Insurance:**

We accept assignment for Medicare as well as other contracted insurances. We will also bill other medical insurances provided we are network providers. Complete coverage from medical insurance is most often not the case. Any unpaid balance is your responsibility. Co-pays, deductibles, and non-insured services are considered your responsibility. For non-contracted insurances the patient must pay for the services in advance. **A statement fee of \$20.00 for each statement beyond the first will be charged. Payment for any non-insured amounts must be received within 10 days in order to not incur additional fees.**

### **Patient Confidentiality:**

In compliance with all state and federal requirements our practice will protect personal health information from disclosure to all parties with exception of those specifically authorized by either statute or by the patient. Your e-mail may be used to contact you for office related matters only. Only the patient e-mail on record will be used to send information without your specific authorization and personal health information will only be sent upon your request.

I have read and agree to the payment policy and *Frame & Lens Policy*.

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Name

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Date