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:

Pharmacy _____
Medical Doctor _____
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 _____

OVER →

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

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

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

Cataracts	☐ No	☐ Yes	Lazy Eye	☐ No	☐ Yes
Dry Eye	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes
Macular Degeneration	☐ No	☐ Yes	Eye Injury	☐ No	☐ Yes
Retinal Tear/Detachment	☐ No	☐ Yes	Eye Turn	☐ No	☐ Yes
Floaters	☐ No	☐ Yes			

Lasik Surgery	☐ No	☐ Yes	Date of Surgery/Which Eye _____
Cataract Surgery	☐ No	☐ Yes	_____
Corneal Transplant Surgery	☐ No	☐ Yes	_____
Injections (Diabetic, Mac. Degen.)	☐ No	☐ Yes	_____
Lid Surgery	☐ No	☐ Yes	_____
Glaucoma Surgery	☐ No	☐ Yes	_____
Laser Surgery (Retina, Cataract)	☐ No	☐ Yes	_____
Eye Turn Surgery	☐ No	☐ Yes	_____

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

Blindness	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes
Macular Degeneration	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes
Eye Turn	☐ No	☐ Yes	Lazy Eye	☐ No	☐ Yes
Retinal Detachment	☐ No	☐ Yes	Hypertension	☐ No	☐ Yes

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

List Eye Medications _____