Medical History Questionnaire

Name: _____ Date of Birth: _____Today's Date: _____

Please assist us in providing you with the most up to date available by telling us a little about your health history.
Do you currently wearing Contact Lens? Yes / No Have you ever worn Contact Lens? Yes / No
When was your last Physical _____ What is your family doctor's name _____
How many hours on average are you on a computer a day? _____

Patient's Medical History

Please Circle yes (Y) below if **you currently** have any of the following or no (N) if you have not.

Constitutional
Y / N Fever, Weight Loss/Gain

Ears/Nose/Mouth/Throat
Y / N Sinus Congestion
Y / N Dry Throat/Mouth

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

Psychiatric
Y / N Anxiety
Y / N Depression

Genitourinary
Y / N Dialysis
Y / N Kidney Failure

Integumentary (Skin)
Y / N Eczema, Skin Cancer

Musculoskeletal
Y / N Rheumatoid Arthritis
Y / N Arthritis
Y / N Muscle/ Joint Pain

Gastrointestinal
Y / N Diarrhea
Y / N Constipation

Allergic/ Immunologic
Y / N Allergies / Hay Fever
Y / N Lupus

Endocrine
Y / N Diabetes
Y / N Hyper/Hypo Thyroid

Cardiovascular
Y / N Heart Pain
Y / N High Blood Pressure
Y / N Vascular Disease
Y / N Elevated Cholesterol

Respiratory
Y / N Asthma
Y / N Chronic Bronchitis
Y / N Emphysema

Neurological
Y / N Headaches/ Migraines

Eyes
Y / N Itching
Y / N Dryness
Y / N Burning
Y / N Tearing
Y / N Tired Eyes/ Pain
Y / N Blurry Vision w /Correction
Y / N Decreased Vision
Y / N Lazy Eye / Crossed Eyes
Y / N Double Vision
Y / N Blindness
Y / N Eye/Head Injury
Y / N Retinal Disease
Y / N Retinal Detachment
Y / N Light Flashes
Y / N Floaters
Y / N Diabetic Retinopathy
Y / N Cataracts
Y / N Glaucoma
Y / N Macular Degeneration

Social History

Do you drink alcohol? **Y** or **N** If yes, how much?_____
Do you smoke? **Y** or **N** If yes how much? _____ How many years? _____ If no, are you a former smoker? **Y** or **N**
Have you ever had a blood transfusion? **Y** or **N**
Does your vision limit your daily activities? **Y** or **N**

Family Medical History

Please circle **yes** below if **anyone in your immediate family** (Mother, Father, Sibling, Maternal/Paternal Grandparent) has a history of any of the following or **No** if they do not. If yes, please list them:

Yes or No	**Arthritis**	
Yes or No	**Rheumatoid Arthritis**	
Yes or No	**High Blood Pressure**	
Yes or No	**Heart Disease**	
Yes or No	**Thyroid Disease**	
Yes or No	**Diabetes**	
Yes or No	**Blindness**	
Yes or No	**Retinal Detachment**	
Yes or No	**Macular Degeneration**	
Yes or No	**Crossed Eyes**	
Yes or No	**Cataracts**	
Yes or No	**Glaucoma**	

Are you currently taking any medications (Including Eye Drops)? **Yes / No** If so, please list the names:

_____
_____
_____
_____

Please list any major surgeries you have had, including eye surgeries:

_____
_____

Do you have any medication allergies? **Yes / No** If so, please list them:

_____
_____

Is there any information on this questionnaire that was not addressed that you would like the Doctor to be aware of? If so, please list it:

_____

Digital Retinal Imaging Screening Authorization Form

We are excited to announce that we have incorporated into our practice a new, highly sophisticated, computerized instrument that allows us to provide a more thorough medical analysis of your eyes. Our new **CANON 15.1 MEGA PIXEL DIGITAL RETINAL CAMERA** takes photographs of your retina (the back of your eye).

We strongly recommend this procedure as part of your exam if:

1) You are a new patient to this office
2) You have never had retinal photos of your eyes
3) You are 65 or older
4) You have or have a family history of high cholesterol, elevated blood pressure or any circulatory disorder
5) You have or have a family history of diabetes or elevated blood sugar
6) You have headaches or visual disturbances suggestive of a neurological problem
7) You have or have a family history of elevated eye pressure or glaucoma
8) You have any retinal disorder such as a detachment, tear, floaters, veils, flashing lights, bleeding or macular degeneration
9) Your vision is not correctable to 20/20 in one or both eyes

"Screening retinal photography" is a necessary part of your eye exam if you fall into any of the above categories. The charge for this procedure is $39.00.

_____ Yes, I want this procedure.

_____ No, I do not want this procedure.

Signature Print name Date

Volunteer Eyecare

Patient Name _____ DOB _____/_____/_____

Email _____ Social Sec # _____-_____-_____

New patients; how did you hear about our practice?:_____

Payment for services and materials is due at the time of your visit

I understand that any services not covered by insurance and co-pays are due at the time of service and that Volunteer Eyecare requires a 50% non-refundable deposit for glasses orders. We cannot order your glasses until the deposit is received. The balance must be paid in full at the time the glasses are dispensed. Contact Lens services and materials are non-refundable. Contact Lenses may not be returned/exchanged if opened. Patients who cancel on the same day of the order will receive a full refund. Please acknowledge acceptance of these policies by your initials and signing and dating the form below.

Initials _____

Retinal Imaging is Recommended as A Reference for Doctors

Digital retinal imaging provides a detailed documentation of the condition of your inner eye so that the doctor can monitor the changes in your eye health over time. If not medically necessary because of a disease or condition, this screening photo will cost you **$39.**

[] Yes I want this service [] No I don't want this service

Life Time Authorization for Insurance Payments

We request your signature on file, in the event the office files insurance for you or for any office procedure. This clause applies to **all insurance carriers.** I request that payment of authorized carrier of Medicare benefits be made either to me or on my behalf to Volunteer Eyecare for any services furnished me by this/these doctors. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Initials _____

Notice of Privacy Practices Patient Acknowledgment

I have had the opportunity to receive this practice's Notice of Privacy Practices. The notice provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practice's legal duties with respect to my protected health information. I understand that the practice may change the terms of its Notice of Privacy Practices and that any changes apply retroactively to information created while the current notice is in effect. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Initials _____

Medicare Does Not Cover the Refraction or Eyewear

As a convenience to our patients, we are a participating provider for Medicare. We will bill Medicare for your visits. Medicare then reviews all claims, and if approved, reimburses our office 80% of the allowed amount. The remaining 20% is your responsibility, called a co-payment. You may also be responsible for an annual deductible and any non-covered fees. Each January, Medicare starts with a new deductible that must be met before claims are paid. If we are the first to file a claim for you this year, it is likely you will not have met your deductible and will owe for the full allowed amount. Medicare does not pay for refractive services. **The cost is $39.** This is the vision evaluation part of the examination that determines your eyeglass prescription. Medicare will not pay for routine eye exam services.

Please sign here _____ Date _____

Relationship to patient if guardian _____