Medical History Questionnaire

Name: _____ Sex: M F Date: _____

Address: _____ Home Phone:_____

City: _____ State: _____ Zip: _____Work / Cell: _____

Birth Date: _____ / _____ / _____ Social Security #: _____ / ____ / _____ Last Eye Exam:_____

Email address: _____

Occupation: _____ Marital Status: _____

Medical Doctor: _____ Phone:_____ Last Exam: _____

How did you hear about us? _____

Medical History

Do you have any allergies to medications? ▢ no ▢ yes If yes, please list: _____

_____

List any medications you take (including oral contraceptives, eye drops, over the counter medications and home remedies):

_____

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

_____

Circle 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**: List any other eye conditions not listed: _____

_____

Are you pregnant and/or nursing? ▢ no ▢ yes

Do you wear glasses? ▢ no ▢ yes If yes, how old is your present pair of glasses? _____

Do you wear contact lenses? ▢ no ▢ yes If yes, how old is your present pair of contacts? _____

Type of contact lenses: ▢ Rigid ▢ Soft ▢ Extended Wear ▢ Other Are they comfortable? ▢ yes ▢ no

Do you plan to get glasses and/or contact lenses today? ▢ no ▢ yes ▢ unsure

Family History

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

DISEASE/CONDITION	YES	?	RELATIONSHIP TO YOU
Blindness	▢	▢	_____
Cataract	▢	▢	_____
Crossed Eyes	▢	▢	_____
Glaucoma	▢	▢	_____
Macular Degeneration	▢	▢	_____
Retinal Detachment/Disease	▢	▢	_____
Arthritis	▢	▢	_____
Cancer	▢	▢	_____
Diabetes	▢	▢	_____
Heart Disease	▢	▢	_____
High Blood Pressure	▢	▢	_____
Kidney Disease	▢	▢	_____
Lupus	▢	▢	_____
Thyroid Disease	▢	▢	_____
Other_____	▢	▢	_____

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.

Do you drive? ▢ no ▢ yes If yes, do you have visual difficulty when driving? ▢ no ▢ yes
How many hours a day to you use digital devices (e.i. Computer, tablet, cell phone) ?_____
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
What are your hobbies?_____

Review of Systems

Please check any problems you currently have for the following areas.

EYES
- ▢ Loss of Vision
- ▢ Blurred Vision
- ▢ Distorted Vision / Halos
- ▢ Dry Eyes
- ▢ Redness
- ▢ Mucous/Discharge
- ▢ Double Vision
- ▢ Retinal Detachment
- ▢ Sandy or Gritty Feeling
- ▢ Itching
- ▢ Excess Tearing / Watering
- ▢ Glare / Light Sensitivity
- ▢ Foreign Body Sensation
- ▢ Burning
- ▢ Eye Pain or Soreness
- ▢ Chronic Infection of Eye or Lid
- ▢ Styes or Chalazion
- ▢ Flashes in vision
- ▢ Floaters in Vision
- ▢ Tired Eyes
- ▢ Cataracts
- ▢ Glaucoma
- ▢ Macular Degeneration
- ▢ Diabetic Retinopathy

GASTROINTESTINAL
- ▢ Colitis
- ▢ Crohn's disease
- ▢ Constipation
- ▢ Ulcers
- ▢ Diarrhea

CONSTITUTIONAL
- ▢ Fever
- ▢ Weight loss/gain
- ▢ Fatigue
- ▢ Trauma

SKIN
- ▢ Eczema
- ▢ Rosacea
- ▢ Psoriasis

NEUROLOGICAL
- ▢ Headaches
- ▢ Migraines
- ▢ Seizures
- ▢ Multiple Sclerosis

ENDOCRINE
- ▢ Type 1 Diabetes
- ▢ Type 2 Diabetes
- ▢ Thyroid Dysfunction
- ▢ Hormonal Dysfunction

RESPIRATORY
- ▢ Asthma
- ▢ Bronchitis
- ▢ Emphysema

CARDIOVASCULAR
- ▢ Heart Disease
- ▢ High Blood Pressure
- ▢ High Cholesterol

EARS, NOSE, MOUTH, THROAT
- ▢ Allergies
- ▢ Sinus Congestion
- ▢ Dry Mouth

ALLERGIC/IMMUNE
- ▢ Drug Allergies
- ▢ Seasonal Allergies
- ▢ Arthritis

LYMPHATIC/BLOOD
- ▢ Anemia
- ▢ Bleeding Problems
- ▢ Leukemia

MUSCULOSKELETAL
- ▢ Fibromyalgia
- ▢ Osteoarthritis
- ▢ Ankylosing Spondylitis

GENITOURINARY
- ▢ Kidney Problems
- ▢ Bladder Problems
- ▢ STDs

OTHER
- ▢ _____
- ▢ _____
- ▢ _____
- ▢ _____

_____ _____ _____
Patient's Signature **Date** **Parent or Guardian's Signature**

NOTICE OF PATIENT PRIVACY RIGHTS, PROTECTION, AND RESPONSIBILITIES

SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION

As a member of a vision care program, I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me if my vision insurance carrier denies or does not cover my claim for these services.

MEDICAL NECESSITY

If my insurance determines that a medical service and/or material are not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material stated below.

CO-PAY'S

I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-payments can not be waived at any time by the provider or service or Bolingbrook Eye Care & Eyewear Gallery.

DEDUCTIBLES

If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider. Yearly deductibles cannot be waived at any time by Bolingbrook Eye Care & Eyewear Gallery.

PROFESSIONAL SERVICES AND MATERIALS

I understand that I am responsible for **100%** of all professional fees rendered on the date of service. I understand I am also required to make payment for at least **50%** of materials at the time materials are ordered. If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold Bolingbrook Eye Care & Eyewear Gallery or my insurance carrier responsible for accidental laboratory breakage. If I do not pick up my materials within **30 days** from my initial order, I will be required to pay for all materials in full or forfeit my deposit. If I am to receive contact lenses by mail, I understand I am required to pay in full at the time of service.

Our Patient Satisfaction Guarantee applies to single vision and progressive lenses. We use only premium single vision optics and premium progressive addition lenses, otherwise known as no line bifocals. Less than one percent of our patients have difficulty adapting to our premium progressive lenses. We will remake a non-adapt progressive lens or single vision lenses one time, in the same frame. If it is still unsatisfactory, we will replace it with a lined bifocal or a single vision lens, in the same frame. While we make every attempt to solve these rare issues, **no refunds will be given in a case where a patient does not adapt to a progressive lens or single vision lens**.

HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician certifications.

AGREEMENT

Date of Signing	Guarantor/Patient Signature	Witness

Print Name