Medical History Questionnaire

FOR YOUR INSURANCE TO REIMBURSE FOR YOUR EYE VISITS, ALL QUESTIONS MUST BE COMPLETED, EACH BOX MARKED YES OR NO

Name: _____ ☐Male ☐ Female Birth Date: _____/_____/_____

Mailing address: _____ Home phone: _____

City: _____ State: _____ Zip: _____ Cell phone: _____

Social Security #: _____/_____/_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Guarantor/Spouse/Parent: _____ Phone: _____

Nearest relative not living with you: _____ Phone: _____

Level of Education: ☐High School ☐College ☐Other: _____ Military Status:_____

Employment Status: ☐Student ☐Emp Part Time ☐Emp Full Time ☐Not Employed ☐Retired ☐Disabled

Occupation: _____ Employer:_____ Work phone: _____

Email address: _____

Financial Waiver

In the event I do not have any insurance, my deductible has not been met, my insurance company does not pay in full or denies payment, I understand that I (Patient or Responsible Party) will be liable for all charges incurred. I understand if I have co-pays, overages or I do not have any insurance my charges will be due and payable at the time of service. There will be a $25.00 returned check fee. Any balance that remains unpaid after 120 days will be turned over to a 3rd party collection agency and will be subject to a 25% collection fee. In the event my balance becomes past due and is referred to a third party agency for collections, by signing this agreement, I agree to be held responsible for any and all cost associated with the collection of my account.

Medical Release Authorization

I authorize Medicare/Insurance to pay benefits directly to Lieblong Eye Clinic for any services or material furnished. I authorize release of medical information needed to process my claims or to determine benefits to the Centers for Medicare Services/Insurance company and its agents. Furthermore, I authorize Medicare/Insurance to furnish to this office any information regarding my claims under Title VIII of the Social Security Act. A copy of this signature is as valid as the original.

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____

MEDICAL HISTORY

Name of Medical Doctor: _____ Phone: _____ Last Seen:_____

Are you: **Pregnant/nursing?** ☐ No ☐ Yes **Allergic to any medications?** ☐ No ☐ Yes, list: _____

List all medications you take (include oral contraceptives, aspirin, over the counter medications), **or provide list**: ☐ None

_____

Has any occupation exposed you to dangerous substances, if yes, please explain: _____

List major injuries, surgeries, hospitalizations: _____

Name of Eye Dr: _____ Phone: _____ Last Exam: _____

Do you wear glasses? ☐No ☐Yes Age of current glasses: _____

Do you wear contacts? ☐No ☐Yes Age of current contacts: _____ Are they comfortable? ☐ No ☐ Yes

Type of contacts: ☐Rigid ☐Soft (Disposable) ☐ Extended wear ☐Other: _____

Have **YOU** ever had: eye infections / injuries: _____

☐ Crossed Eye ☐ Lazy Eye ☐ Drooping Eyelid ☐ Prominent Eyes ☐ Retinal Disease ☐ Cataracts ☐ Glaucoma

FAMILY HISTORY

Please note any **FAMILY HISTORY** (parents, siblings, grandparents, children) of the following conditions:

DISEASE/CONDITION	NO	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: _____	☐	☐	☐	_____

Please turn over and complete other side*

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 If yes, please describe:

_____

Do you use tobacco? ☐ No ☐ Yes If yes, type /amount / how long: _____

Do you drink alcohol? ☐ No ☐ Yes If yes, type / amount / how long: _____

Do you use recreational drugs? ☐ No ☐ Yes If yes, type/ amount / how long: _____

Have you ever been exposed to or infected with: Gonorrhea, Hepatitis, HIV, Syphilis ☐ No ☐ Yes (circle all applicable)

REVIEW OF SYSTEMS Do **YOU** currently or ever had any problems in the following areas:

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

	NO	YES	?
EARS, NOSE, 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	☐	☐	☐
GENITOURINARY			
Genitals / Kidney / Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

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

_____

_____

_____

_____ _____

Doctor's Signature **Date**