Confidential Patient History Questionnaire

Today's Date:_____
Legal Last Name:_____
Legal First Name:_____
Preferred Name:_____
Middle Initial:____DOB:_____Gender M F
Social Security:_____
Social Security number is needed if we are billing insuance

Mailing Address:_____
Physical Address:_____
City:_____State:_____Zip:_____
Home Phone:_____
Cell Phone:_____
Work Phone:_____
Email:_____
Employer:_____

Guardian/parent of the patient
Name:_____
Relationship to Patient:_____
Phone Number:_____
Mailing Address:_____
Physical Address:_____
City:_____State:_____Zip:_____
Social Security:_____
Employer:_____
Divorced parents we are not a party to the divorce agreement. Therefor, the responsible party is the parent who accompanies the child to our office

Insurance:_____
Policy Member:_____DOB:_____
Relationship to patient:_____
Employer:_____
We will need a copy of your card. We will only file a claims 2 times and then it becomes your responsibility.

Medical History
How is your general health?_____
Do you have Diabetes? Y N How long? _____
Do you have any problems with the following:
- Headaches - Y N
- Migraines - Y N
- Respiratory (Breathing) - Y
- Seizures - Y N
- Ears, Nose, Throat? - Y N
- Heart/High Blood Pressure - Y N
- High Cholesterol - Y N
- Diarrhea - Y N
- Constipation - Y N
- Kidneys - Y N
- Bladder - Y N
- Arthritis - Y
- Muscle or Joint Pain - Y N
- Anemia - Y N
- Bleeding Problems - Y N
- Thyroid - Y N
- Allergies - Y N
- Mental - Y N
- Psychiatric - Y N
- Cancer - Y N
- Are you pregnant - Y N
  How far along _____

Family History
Does anyone in your family have the following?
Who?
- Blindness Y N _____
- Cataract Y N _____
- Glaucoma Y N _____
- Cross Eyes Y N _____
- Macular Degeneration Y N _____
- Retinal Detachment or Disease Y N

_____
- Arthritis Y N _____
- Cancer Y N _____
- Diabetes Y N _____
- Heart Disease Y N _____
- High Blood Pressure Y N _____
- High Cholesterol Y N_____
- Kidney Disease Y N _____
- Lupus Y N_____
- Thyroid Disease Y N _____
- Other

_____
_____
_____

OVER

Please Explain answers marked yes:
Eye Health & Information
Do you wear Glasses? Y N
Do you wear Contacts? Y N
Brand:_____
Do you have or have had any of the following:

- Cataracts Y N
- Cataract Surgery Y N
- Crossed Eyes Y N
- Retinal Disease Y N
- Eye Injury Y N
- Lazy Eye Y N
- Glaucoma Y N
- Macular Degeneration Y N
- Keratoconus Y N

Any major injuries or surgeries to your eyes?
_____
_____
_____
Please explain any problems that you are having with your eyes or
vision:_____
_____
_____
_____

Medication

Are you allergic to any medications?
Please list them:
_____
_____

Do you take any medications (include over the counter meds as well)?
Please list them and how often you use them:
_____
_____
_____
_____
_____

Social History

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

I would prefer to discuss with the doctor? Y N
Do you drive? Y N
Do you use any of the following?

- Tobacco Y N
- Alcohol Y N
- Illegal Drugs Y N

Please sign indication that you have had the opportunity to read our Notice of Privacy Practices, authorizing the release of medical or other information necessary to process your insurance claim, and authorizing insurance benefits to be paid directly to Heart Mountain Eyecare Group. You will be responsible for non-covered charges.

I have read the information to the left. I understand and agree to it. I verify that all the information I have filled out is true and correct.

Signature:_____