



PATIENT HISTORY QUESTIONNAIRE

(completion required at each patient appointment)

Welcome to our office

Title () Last name _____ First name _____ MI _____ Date _____
(Mr., Mrs., Ms., Miss, Dr.)

Name you wish to be called _____ Age _____ Birthdate _____ SSN _____

Home Address _____ City _____ State _____ Zip _____

Employer/School _____ Occupation _____ (Please mark preferred)

Name of Parent, Legal Guardian or Spouse _____ Cell _____

Name of family members whom we have provided care _____ Home _____

Insurance Company _____ ID# _____ Work _____

Subscriber name _____ Relationship to patient _____ E-Mail _____

Subscriber Birthdate _____ Letter _____

Race (Optional):

- American Indian or Alaskan Native Asian Black or African American
- Native Hawaiian or Other Pacific Islander White or Caucasian

Ethnicity (Optional):

- Hispanic or Latino
- Not Hispanic or Latino

Preferred Language: _____

Medical History / Review of Systems:

List any medications you are now taking (including eye drops, birth control pills, vitamins or over the counter medications):

Are you allergic to any medications? Yes No Please list: _____

Primary Care Physician: _____ Pediatrician: _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

Do you have or have you ever had any of the following conditions:

- | | |
|--|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Asthma/COPD | <input type="checkbox"/> No <input type="checkbox"/> Yes Gastrointestinal Conditions (ulcer, abdominal pain, diarrhea) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes Heart Conditions |
| <input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes Musculoskeletal Conditions |
| <input type="checkbox"/> No <input type="checkbox"/> Yes High Cholesterol | <input type="checkbox"/> No <input type="checkbox"/> Yes Neurologic (numbness, weakness, headaches, prior stroke) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Thyroid Conditions | <input type="checkbox"/> No <input type="checkbox"/> Yes Psychiatric Conditions (depression, anxiety) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Pregnant/Nursing | <input type="checkbox"/> No <input type="checkbox"/> Yes Respiratory Conditions (shortness of breath, wheezing) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis | <input type="checkbox"/> No <input type="checkbox"/> Yes Seasonal Allergies |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Chronic fever, unexpected weight loss/gain, fatigue | <input type="checkbox"/> No <input type="checkbox"/> Yes Skin Conditions (rashes, excessive dryness, rosacea) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Ear/nose/throat (hearing loss, sinus) | <input type="checkbox"/> No <input type="checkbox"/> Yes Urinary Conditions (pain or discomfort, blood in urine) |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Endocrine Conditions | |

Other Condition/Illness _____

List any previous major injuries/surgeries/hospitalizations: _____

Eye History: Do you have or have you ever had any of the following conditions:

- Blurred Vision Cataracts Double Vision Dry Eye Eye Injury Eye Surgery Flashes Floaters Glaucoma
- Lazy/Crossed Eye Loss of Vision Macular Degeneration Migraine/Headache Retinal Detachment

Are you interested in correcting your vision with LASIK Surgery? Yes No

Marital Status: Single Married Other

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No If yes, please describe: _____

Family History (Please use the checkboxes to indicate who in your family had the condition.)

| | <u>Parent</u> | <u>Sibling</u> | <u>Child</u> | | <u>Parent</u> | <u>Sibling</u> | <u>Child</u> |
|---------------------------------|--------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|--------------------------|
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cataract | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lazy/Crossed Eye | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Retinal Detachment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Eye Disease or Condition: | _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Smoking History

Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoker Smoker (Current Status Unknown)

Do you drink alcohol? Yes No _____ Do you use illegal drugs? Yes No _____

Have you ever been exposed to or infected with: HIV Hepatitis

If patient is 18 or under, please complete:

Any prenatal, perinatal, or postnatal problems? Yes No _____

Any developmental problems? Yes No _____

Do you have any concerns with your child's school performance? _____

Last eyecare provider: _____ Date of last eye exam _____

Are you currently having eye or vision problems? Yes No

If yes, please explain _____

Do you wear glasses? Yes No How old are they? _____ Are they bifocals? Yes No Are they for Reading Distance Both

Have you ever worn contact lenses? Yes No If yes, when were they prescribed? _____

Do you wear contacts now? Yes No If not, why did you quit? _____

Are you interested in wearing contact lenses? Yes No If yes, please read the following information regarding contact lenses.

Rinkov Eyecare Centers prescribes quality contact lenses to improve your vision and your lifestyle. Contact lenses are FDA regulated medical devices that can cause discomfort, infections, and even permanent vision loss if not cared for properly. New and existing contact lens wearers require additional time and testing during an eye examination to minimize the risk of serious eye problems. This additional testing is only done for contact lens wearers, not for patients who do not wear contact lenses. For this reason, there are additional contact lens evaluation and services fees for new and existing contact lens wearers. Your contact lens evaluation and services fee includes:

1. Specific curvature measurements of the corneas
2. Evaluation of current and new lenses to ensure optimal fit, vision and comfort
3. Medical assessment of the cornea, tear film and conjunctiva as they relate to contact lens wear
4. Instructions regarding safe contact lens wear, care and proper cleaning and solutions
5. Contact lens follow up care for 90 days

If you have any questions, please do not hesitate to speak with your doctor.

Payment for all services and products is the responsibility of the patient.

I agree to pay all copays, deductibles, co-insurances and non-covered services as determined by my insurance company.

I understand there is a returned check fee applied to every returned check.

I agree to pay an additional 25% of the amount owed as a collection fee for all accounts not paid in the time stated on the final monthly statement.

I authorize the release of medical information concerning my illness and treatment by Rinkov Eyecare Centers to my insurance company.

I also authorize the release of my personal medical information to any doctor whom I may be referred to.

I understand verification of eligibility is not a guarantee of payment as stated by my insurance company.

I authorize payment of my insurance benefits to Rinkov Eyecare Centers.

We will file all insurance forms if Rinkov Eyecare Centers is a participating provider for your plan.

We will supply you with an itemized statement which you may submit to your insurance carrier.

PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE

Signature of patient or legal guardian

Today's Date