



# PATIENT HISTORY QUESTIONNAIRE

(completion required at each patient appointment)

Welcome to our office

Title ( ) Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  Male  Female  
(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): \_\_\_\_\_ Ethnicity (Optional): \_\_\_\_\_

American Indian or Alaskan Native  Asian  Black or African American  Hispanic or Latino

Native Hawaiian or Other Pacific Islander  White or Caucasian  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 currently have 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.)

	Parent	Sibling	Child		Parent	Sibling	Child
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.

Eyecare Associates of Kentucky 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 Eyecare Associates of Kentucky 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 Eyecare Associates of Kentucky.

We will file all insurance forms if Eyecare Associates of Kentucky 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