MEDICAL HISTORY QUESTIONNAIRE

Name: ____ **Date:** ____
Phone #: ____ **Address:** ____
Social Security #: ______________________________ ____
Email: ____ **Occupation:** ____
Date of Birth: _____________________ **Male:** _______ **Female:** _______

Chief Complaint: ____
A medical complaint includes blurry vision, watery, itchy eyes, flashes, floaters, vision loss, pain, light sensitivity, pressure, etc. If you do not have a medical complaint and are here for a routine check-up, then MEDICARE will not cover this exam.
PCP: _______________________________ PCP PH #___________________________ PCP Fax #__________________________
How did you hear about us?: Doctor Referral ______ Facebook ______ Flyer _______ TV _______ Friend _______
Date of last eye exam: ______________________ Location of last eye exam: ____
List any medications you currently take (Rx and over-the-counter): ____
____
Do you have allergies to any medications? **YES NO** If YES, list the medications: ________________________________
____
List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.): ________________
____
List any surgeries you have had (cataract, appendectomy): ____

Do you currently have any problems in the following areas?

	YES	NO		YES	NO
EYES (poor vision, eye pain, tearing, redness, etc.)			**FEMALES** Are you pregnant? Nursing?		
PSYCHIATRIC (anxiety, depression, insomnia)			**CARDIOVASCULAR** (high BP, racing pulse, etc.)		
ENDOCRINE (diabetes, hypothyroid, etc.)			**SKIN** (pimples, warts, growths, rash, etc.)		
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.)			**BLOOD** / **LYMPH** (bleeding, cholesterolemia, anemia, blood transfusion, etc.)		
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			**ALLERGIC** / **IMMUNOLOGIC** (sneezing, swelling, redness, itching, hives, lupus, etc.)		
RESPIRATORY (congestion, wheezing, short of breath, etc.)			**GENITAL**, **KIDNEY**, **BLADDER** (painful urination, frequent urination, impotence, jaundice, etc.)		
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			**EARS, NOSE, THROAT** (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)		

FAMILY HISTORY

Has any member of your family had these diseases? (circle all that apply) **YES NO UNKNOWN**
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid, Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**
Have you ever had a blood transfusion? **YES NO** Do you drink alcohol? **YES NO** If YES, how much? _________
Do you smoke? ....**YES NO** If YES, how much? ___________ How many years? ____________

The Florida Board of Optometry has established that a comprehensive eye examination for a new patient includes a Dilated Exam. This procedure involves putting one or more drops in each eye that will dilate the pupils. The doctor will then study the internal structures of the eye to ensure proper health. The drops will cause the eyes to be light sensitive and vision will be blurred, especially with near work, for 4-6 hours. Some patients the effects will be longer. Driving may be difficult and should be done with extreme caution.
_____ Agree to have my eyes dilated. **_____ Do not agree to have my eyes dilated.**

Patient Signature/Patient's Legal Representative: ____ **Date:** ______________________

Physician's Signature:____ **Date:**______________________

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Medical Information: **Please place a check in the blank if the described condition applies to you.**

Allergies: Do you have seasonal allergies?_____ Itchy eyes?_____ Chronic sinus infections?_____
Ocular Muscles: Do you have strabismus (turned eye)? _____ Prism in your glasses?_____
Did you ever have vision therapy? _____ Do you ever see double?_____
Optical: Do you have problems with glare? _____ Work on a computer? _____ Participate in sports? _____
Blurred vision with current glasses?_____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Eye Doctor's Optical Outlets as your eye care provider. Our mission is to ensure the health of your eyes with all of your eyeglass and contact lens needs. We ask that you carefully read and sign this form, acknowledging your understanding of our policies.
*Some insurance plans have co-pays for eye exams. Ask us to review your benefits to find out if a copay will be due for your eye exam, as this fee is due at the time of service.
*Contact lens evaluation and fitting: Not all insurance plans offer benefits that cover contact lens evaluations and/or fittings. If you are using insurance and would like a contact lens evaluation, ask us to review your benefits and possible out-of-pocket costs PRIOR to your examination. All fees associated with the contact lens evaluation are due in full at the time of service.
*Fees for contact lens evaluations include a trial set of contact lenses, insertion and removal training if you are a new contact lens wearer, and follow-up visits for up to 90 days after your initial exam. If your doctor recommends a follow-up visit and you do not comply within 90 days, your contact lens prescription may not be finalized and you will be responsible for a new exam, in its entirety, out of pocket.
*When purchasing glasses, payment is due in full when the order is placed. ALL SALES ARE FINAL; if you wish to add or remove any features from your lenses, wish to change the frame, etc., you may be responsible for the cost of a new pair of glasses. If for any reason you have a concern with your eyeglass prescription, the doctor will schedule a follow-up exam within 90 days of your original exam. If a change is made to your prescription, we will remake your lenses at no charge. NO REFUNDS WILL BE ISSUED; if you are dissatisfied with your purchase for any reason and wish to return the glasses, you have 30 days to do so and will receive STORE CREDIT ONLY.
*When purchasing contact lenses, payment is due in full when the order is placed. Opened boxes cannot be exchanged.
By signing down below you acknowledge that you have read and understand the above information and agree to the terms set forth in this agreement. You are also acknowledging that all of your questions have been answered.

HIPAA PRIVACY (Acknowledgement of Receipt of Privacy Notice)

By signing below, I acknowledge and agree that I have received a copy of this notice for review and to keep for my records on the date identified below. I understand that the Optical Outlet's independent doctor and Optical Outlets itself may use and disclose necessary to: perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by Optical Outlets and its contractors. Optical Outlets or its delegated third party may communicate with me regarding vision care products and services provided by Optical Outlets including phone, text, email and mailings regarding eye exams, appointment reminders, and recommended products and services provided by Optical Outlets. Such communications may be through automated messages and dialers. Be assured that Optical Outlets and its affiliates do not sell your personal health care or contact information to any third party for another party to use the information for that party's benefit.

Patient Signature or Patient's Legal Representative: ____ Date: _________________

Physician's Signature:____ Date:________________________