Patient Information and Medical History Questionnaire

Thank you for allowing us to treat you! **Please Print**. Circle your answer when appropriate.

Name: ______________________________ Date: ______________

Street Address: ______________________ Apt # ______ City______________ State _____ Zip ________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

E-Mail Address: ______________________________

Date of Birth: ______________ Age: _____ Sex: **M F** SS#: ______________

Employer (or School): ______________________ Occupation (or Grade): ______________________

Last Medical Exam ______ Dr.'s Name: ______________ Last Eye Exam ________ Dr.'s Name: ______________

Women: Are you pregnant or nursing? **N Y** Due Date: ______________

MEDICAL HISTORY

What is the reason for your visit today? ______________________________

Have you had eye surgery? If yes, please explain ______________________________

Have you had: crossed eyes, lazy eye, drooping eye lid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injuries?

Y / **N** if yes, please explain ______________________________

Circle if you have or if you had ever had any problems in the following areas:

Loss of Vision   Loss of Side Vision   Blurred Vision   Double Vision   Dryness   Redness

Distorted Vision/Halos   Sandy/Gritty Feeling   Flashes/Floaters in Vision   Mucous Discharge

Are you being treated for a medical condition? **N Y** if yes, please explain ______________________________

Do you have allergies to any medications? If yes, please list ______________________________

List all medications you are taking ______________________________

____

Describe your computer use: ___ Extensive (5+ hrs/day) ___ Moderate (1-4hrs/day) ___ Low 1hr/day or less ___ Seldom

Do you wear glasses? **N Y**   Do you wear contacts? **N Y**   If yes, what type? (circle which applies)

Soft Daily Wear   Disposable   Extended wear   Toric   Monovision   Multifocal   RGP (rigid gas permable lens)

Brand if known ______________ Are they comfortable? **N Y** Are you interested in contact lenses today? **N Y**

How old are the contacts you are currently wearing? ______________ How often do you replace your lenses? ____________

SOCIAL HISTORY

Do you: Use tobacco products? N Y   Drink alcohol N Y   Use illegal drugs? N Y

Hobbies/sports ______________________________

FAMILY HISTORY

Is there any family medical history of any of the following? (If yes, please list their relationship to you)

CONDITION	NO	YES	WHO?	CONDITION	NO	YES	WHO?
Glaucoma	☐	☐	________	Diabetes	☐	☐	________
Cataract	☐	☐	________	Cancer	☐	☐	________
Macular Degeneration	☐	☐	________	Heart Disease	☐	☐	________
Retinal Detachment	☐	☐	________	High Blood Pressure	☐	☐	________
Lupus	☐	☐	________	Thyroid Disease	☐	☐	________

Other ____

CONTINUED ON BACK

REVIEW OF SYSTEMS

Please *circle or check-off* if you currently, or have you ever had any problems in the following areas:

CONSTITUTIONAL`
- Fever
- Weight loss/gain

VASCULAR/CARDIOVASCULAR
- Heart disease
- Stroke
- High Blood Pressure/HTN
- High Cholesterol

EARS, NOSE, MOUTH, THROAT
- Allergies/Hay Fever
- Sinus Congestion
- Dry Throat/Mouth

RESPIRATORY
- Asthma
- Emphysema

GASTROINTESTINAL
- Crohn's Disease
- Colitis
- Ulcer

GENITOURINARY
- STD: Herpes, Chlamydia, HIV

MUSCULOSKELETAL
- Fibromyalgia
- Muscle/Joint Pain
- Osteoarthritis

INTEGUMENTARY (SKIN)

NEUROLOGICAL
- Headaches
- Migraines
- Seizures

PSYCHIATRIC
- Depression
- Panic Disorder

ENDOCRINE
- Diabetes Type 1
- Diabetes Type 2
- Thyroid Dysfunction

LYMPHATIC/HEMATOLOGIC
- Anemia
- Leukemia

ALLERGIC/IMMUNOLIC
- Environmental Allergies
- Rheumatoid Arthritis
- Lupus

CANCER
- Type: _________________________

NONE OF THE ABOVE

DIAGNOSTIC TESTING

We strongly encourage all our patients to have the following tests performed. They are especially important for anyone over 35 years of age, patients who have high blood pressure, diabetes, retinal problems, headaches, floaters, flashing lights, a strong prescription, or a family history of eye disease. These tests are in addition to a wellness examination. Your doctor may determine one or both of these tests necessary for your comprehensive eye health examination. A medical condition may require these procedures and allow for your General Medical Insurance to cover a portion of the fees (the patient is responsible for the remaining balance). If there is no General Medical Insurance and/or no medical diagnosis, the fees for screening are due at the time of service.

Automated Visual Field Analysis

The Automated Visual Field Analysis assists the doctor with early detection and diagnosis of Glaucoma, Macular Degeneration, Retinal Diseases, Neurological and Vascular Disease, etc.

YES, I wish to have Automated Visual Field Analysis **($15 Fee)**

NO, I do not wish to have Automated Visual Field Analysis

Please INITIAL for one of the following:

Digital Retinal Photography

Photographs of the inside of the eye can assist the doctor with the early detection of Macular Degeneration, Glaucoma, Cataract, Diabetes, High Blood Pressure, Optic Nerve Disease, etc.

_____ ***"I approve an extra $35 fee for this procedure (****if not covered by insurance****)."***

OR

Ocular Dilation

Pupil dilation involves placing drops in the eye to relax the pupil. This allows the doctor to more completely evaluate the health of your eyes. It also assists the doctor with early detection of many eye disease and conditions. Pupil dilation may affect your vision and make you light sensitive. Contact us if you experience any usual side effects that could include swelling, pain, or unusually prolonged blurred vision following the dilation of your eyes.

_____ ***"I do NOT approve of having this special testing today but consent to dilation."***

INFORMED CONSENT OF TREATMENT

"I consent to treatment by Ta Eye Associates, PLLC."

______________________________ ______________________________ __________

Patient signature *Guardian Signature under 18* *Date*

(Your signature denotes your understanding of informed consent)

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES

I acknowledge that I have been informed of the Patient Privacy Policy of this office in accordance with the Federal Health Insurance Portability and Accountability Act (HIPAA).

______________________________ ______________________________ __________

Patient signature *Guardian Signature under 18* *Date*

INSURANCE INFORMATION

Policy Holder's Name: ______________________________ DOB: ______________

SS# or ID # ______________________________ Relationship to Insure: Self / Spouse / Child/ Other

I authorize Ta Eye Associates, PLLC to use “SIGNATURE ON FILE” in actual signature on insurance claim forms.

Assignment of Benefit

I authorize payment of medical benefits to Ta Eye Associates, PLLC for services rendered. I understand that I am financially responsible for all Charges not paid by my insurance plan.

Sign______________________ Date _______

Release of Information

I authorize the release of information regarding my treatment or condition in order to obtain payment for Professional Services.

Sign _____________________ Date ______