Patient History Questionnaire

Person Responsible for Account:________________________________ Today's Date ___________________________

Last Name___________________________________ First Name____________________________ MI_____________

Address ____ City __________________ State ______ Zip ____________

Daytime Phone __________________________________ Cell Phone ____

Birthdate ____/____/____ Occupation __________________________ Employer ____________________________

Emergency Contact Name ______________________________ Phone ___________________________________

Date of Last Eye Exam ________________________ How did you hear about us? _______________________________

Vision Insurance _______________________________ Health Insurance __________________________________

Vision Insurance Member ID ______________________ Who is the Primary Cardholder? _________________________

Medical Information

Medical History: Please list any diagnosed medical conditions (Hypertension, Diabetes, etc.), and date of diagnosis

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Ocular History: Please check any diagnosed eye conditions ☐ Macular degeneration ☐ Inflammatory Disorder
☐ Cataract ☐ Strabismus ☐ Keratoconus ☐ Amblyopia ☐ Glaucoma suspect ☐ Glaucoma ☐ Surgery
☐ Retinal degeneration/hole/detachment ☐ Patching ☐ Eye Injury/Trauma

Explain: ____

Do you wear glasses?______ Contact Lenses? ______ If so, Type? ________________ Brand? ____________________

Do you sleep in your contact lenses? _______ If so, how long without removing? _______________________________

Medications: Please list medications you take (including oral contraceptives, over-the-counter, & home remedies)

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Drug Allergies: ____

Are you pregnant and/or nursing? ________________ Primary Physician ______________________________________

Family History

High Blood Pressure	Yes/No	Relation__________	Diabetes	Yes/No	Relation____________
Thyroid Disease	Yes/No	Relation__________	Cancer	Yes/No	Relation____________
Macular Degeneration	Yes/No	Relation__________	Glaucoma	Yes/No	Relation____________
Retinal Detachment	Yes/No	Relation__________	Cataracts	Yes/No	Relation____________
Strabismus	Yes/No	Relation__________	Amblyopia	Yes/No	Relation____________
Severe Myopia	Yes/No	Relation__________	Other	Yes/No	Relation____________

Social History (Kept strictly confidential. If you prefer, you may opt to discuss this portion directly with the doctor)

☐ Yes, I prefer to discuss my Social History information directly with the doctor.

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

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Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long _______________________________

Are you a ☐ Former smoker ☐ Current occasional smoker ☐ Current every day smoker

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long _______________________________

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long _______________________________

- OVER –

Review of Systems

Do you currently, or have you ever had, any problems in the following areas (please check only if applicable):

1. **Eyes** ☐ Itch ☐ Double vision ☐ Burning ☐ Mattering ☐ Vision Loss ☐ Light Sensitivity ☐ Redness ☐ Floaters ☐ Loss of Sharpness ☐ Flashes of Light ☐ Tearing Other ____________________________
2. **Constitutional** ☐ Developmental Disorders ☐ Cancer ☐ Fatigue Syndrome Other ________________________
3. **Ear, Nose, Mouth, Throat** ☐ Sinusitis ☐ Dry Mouth ☐ Hearing Loss ☐ Laryngitis Other ________________________
4. **Neurological** ☐ Epilepsy ☐ Seizure Disorder ☐ Tumor ☐ Stroke/CVA ☐ Migraine Other ______________________
5. **Psychiatric** ☐ Depression ☐ Bipolar ☐ Anxiety ☐ Attention Deficit Other __________________________
6. **Vascular/Cardiovascular** ☐ Vascular Disease ☐ Stroke ☐ Heart Disease ☐ High Blood Pressure ☐ Congestive Heart Failure Other ____________________________________
7. **Respiratory** ☐ Cigarette Smoker ☐ Bronchitis ☐ COPD ☐ Emphysema ☐ Asthma ☐ Sleep Apnea Other _________________________________
8. **Gastrointestinal** ☐ Celiac Disease ☐ Crohn's Disease ☐ Ulcer ☐ Colitis ☐ Acid Reflux Other __________________
9. **Genitourinary** ☐ Kidney Disease ☐ STD – Herpetic/Chlamydia ☐ Prostate Disease/Cancer ☐ Pregnant/Nursing Other ____
10. **Musculoskeletal** ☐ Arthritis ☐ Ankylosing Spondylitis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Osteoarthritis ☐ Gout Other ____
11. **Integumentary (Skin)** ☐ Herpes Simplex/Cold Sores ☐ Herpes Zoster/Shingles ☐ Rosacea ☐ Psoriasis ☐ Eczema Other ____
12. **Endocrine** ☐ Diabetes Type I ☐ Diabetes Type II ☐ Thyroid Dysfunction ☐ Hormonal Dysfunction Other ______
13. **Hematologic/Lymphatic** ☐ Large Volume Blood Loss ☐ Anemia ☐ Ulcer ☐ High Cholesterol Other _____________
14. **Allergic/Immunologic** ☐ Environmental Allergies ☐ Lupus ☐ Rheumatoid Arthritis ☐ Drug Allergies ☐ Sjogren's Syndrome Other ____

If you checked any of the above, or have a condition not listed, please explain:

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HIPAA Privacy – Acknowledgement of Receipt of Notice of Privacy Practices

I, ____ (Print full legal name),
The "Patient"/"Patient's Legal Representative" (circle one)

Have been provided with the NOTICE OF PRIVACY PRACTICES POLICY (the "POLICY") of MANSFIELD VISION CENTER (the "PROVIDER"), and have been offered a copy of such policy to keep for my records.
__________ (Initial to acknowledge receipt of the privacy policy)

__________(Initial to refuse receipt of the policy). I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.

SIGNATURE ____ Date ___________________________

For Patients with Vision Insurance Coverage – Please Read and Sign the Following

In the event your vision insurance provider determines that you are not eligible for vision insurance coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by your insurance provider.

SIGNATURE (Patient or Guardian) ____ Date ________