Mansfield Vision Center

Patient History Questionnaire

Person Responsible for Account:_____ Date _____
Last Name_____ First Name_____ MI____
Address _____ City _____ State ___ Zip _____
Daytime Phone _____ Cell Phone _____ Home Phone _____
Birthdate (MM/DD/YY) _____ Occupation _____ E-Mail _____
Emergency Contact _____ Relationship _____ Phone _____
Last Eye Exam Date (MM/DD/YY) _____ How did you hear about us? _____
Vision Insurance _____ Health Insurance _____
Vision Insurance Member ID _____ Who is Primary Cardholder? _____

Medical Information

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

_____

_____

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)

_____

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:

_____

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long _____
Are you a: ☐ Former smoker ☐ Current occasional smoke ☐ 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 _____

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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** ☐ Fibromyalgia ☐ Ankylosing Spondylitis ☐ Arthritis ☐ 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:

_____

_____

HIPAA Privacy – Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (Print full legal name),

(CHECK one) The ☐ "Patient" ☐ "Patient's Legal Representative"

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.

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 _____

We are preparing to start our Social Media Program in response to our patient requests. Our office software provider is working on integrating this ability into our office system. Meanwhile, we would like to get your ID on favorite social media apps. **We WON'T spam you with ads or promotions but would like to stay in touch**. Please list them below, Thank You!

My Social Media ID's - FB _____ Other _____