

Medical History Questionnaire

Name: _____ Today's Date: _____
 Address: _____ Phone: _____
 _____ Work Phone: _____
 Guardian (If Applicable): _____ Occupation: _____
 Email: _____ Preferred Language: _____
 Birth Date: _____ Social Security #: _____ Race/Ethnicity: _____
 Gender: _____ Date of Last Eye Exam: _____ Date of Last Medical Exam: _____
 Name of Medical Doctor: _____ Dr.'s Phone: _____

Medical History

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had:

Check any of the following that you have had: crossed eyes lazy eye drooping eyelid prominent eyes
 Glaucoma retinal disease cataracts eye infections eye injury

Are you pregnant or nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no

Family History: note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions.

Disease/Condition	No	Yes	?	Relationship To You	Disease/Condition	No	Yes	?	Relationship To You
Blindness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment or Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lupus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
					Other: _____				_____

* Please Turn This Form Over & Complete Side Two *

Social History: *This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.*

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

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: _____

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: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems: Do you currently, or have you ever had any problems in the following areas?

System	NO	YES	?	System	NO	YES	?
Constitutional				Ears, Nose, Mouth, Throat			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes				Respiratory			
Loss of Vision.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular / Cardiovascular			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones / Joints / Muscles			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection, Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic / Hematologic			
Tired Eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic / Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

Doctor's Signature

Date

PATIENT REGISTRATION FORM

Date: ____/____/____

Last Name: _____ First Name: _____ MI _____

Title: Mr. Mrs. Ms. Miss. Other _____ M F Head of Household: Y N Birth Date: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Social Security #: ____/____/____

Email: _____ (for reminders or notifications)

Patients Occupation: _____ Patient's Employer: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Employer: _____ Work Phone: _____

If patient is a minor, list parent or guardian's name: _____

RESPONSIBLE PARTY INFORMATION - (If different from above)

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Birth Date: ____/____/____ Relationship: _____

RELEASE OF INFORMATION AND BENEFIT AUTHORIZATION

The undersigned authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature authorizes this office to submit claims for benefits to the insurance carrier for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents that will be bound by this signature as though the undersigned has personally signed the particular claim. I authorize payment of medical benefits to this office for services rendered and submitted. I understand that I am personally responsible for payment of these services and materials (with the exception of Medicaid and some parts of Medicare).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Signing this document also signifies that you have received a copy of our *Notice of Privacy Practices*. In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. I acknowledge that I have received the *Notice of Privacy Practices* from Paul Bigelow, O.D., P.C., 230 W Mallard Drive, Boise, ID 83706. 208-342-4841

Signature: _____ Date: _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient: _____ Print Name: _____

Source of Authority: _____

Please check the reason(s) you chose our office for your eye care:

Family Referral ___ Friend Referral ___ Yellow Pages: Dex ___ Impact ___ Yellow Book ___ Previous Patient Here ___
Office Location ___ Insurance ___ Other ___

Is there someone we may thank for referring you to us? _____