Meador Eye Clinic

Welcome to our office. We appreciate your completing this medical history questionnaire.

DUE TO REGULATIONS NO QUESTIONS CAN BE LEFT UNANSWERED

(Mr., Mrs., Ms., Dr.)

Name: _____ Parents (if minor) _____

Address _____ City_____ State _____Zip _____

Date of Birth _____/_____/_____ Home Phone _____ Work Phone _____Cell_____

E-mail address _____ (We will not release your e-mail address to any other party.)

Social Security Number_____ (For insurance billing only.)

MEDICAL HISTORY

Do you have allergies to any medications? YES NO

If YES, please list the medications _____

Please list any medications you currently take (prescription and over-the-counter) _____

_____

Females—are you pregnant or a nursing mother? YES NO MAYBE

Do you currently, or have you ever had significant problems in the following areas:

REVIEW OF SYSTEMS	YES	NO	DETAILS
ALLERGIC/IMMUNOLOGIC (allergies, hay fever, hives, lupus, fibromyalgia, etc.)			
CARDIOVASCULAR (high blood pressure, heart or vascular disease, stroke, etc.)			
GENERAL/ CONSTITUTIONAL (current fever, unexplained weight loss or gain, unusual fatigue)			
ENDOCRINE (diabetes, thyroid disease, etc.)			
GASTROINTESTINAL (stomach upset, ulcer, hernia, etc)			
GENITOURNINARY (genitals, kidney, bladder)			
EAR, NOSE, THROAT (hearing loss, chronic cough, dry mouth, sinus congestion etc.)			
BLOOD/ LYMPH SYSTEM (bleeding, anemia, high cholesterol)			
SKIN (acne, rash, skin cancer etc.)			
MUSCULOSKELETAL (muscle aches, joint pain, arthritis, rheumatoid arthritis)			
NEUROLOGICAL (headache, migraines, seizures, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
RESPIRATORY (asthma, bronchitis, emphysema, etc.)			

FAMILY HISTORY

(Includes parent, grandparent, sibling)

Has any member of your immediate family had a history of these conditions? (Please circle all that apply)

Blindness cataract glaucoma macular degeneration retinal disease or detachment crossed eyes or lazy eye

diabetes high blood pressure heart disease stroke cancer thyroid disease arthritis

See back -->

SOCIAL HISTORY

Occupation _____ Employer _____

Students---what grade/class are you in? _____ School _____

Do problems with your vision limit your daily activities (driving, reading, working, etc.)? YES NO

Do you have a history of alcohol or substance abuse? YES NO

Do you use tobacco products? YES NO

If so how long? _____ Height _____ Weight _____

Current marital status: Married Single Widowed Divorced Separated Minor

Name of Spouse if Married: _____

Spouses place of employment: _____

EYE HEALTH HISTORY

Have you ever had (please circle all that apply)

Eye injury eye infection eye surgery glaucoma cataract retinal disease crossed eye lazy eye

Date of last eye exam _____ Do you currently wear *glasses contacts both neither*

Do you have problems in any of the following areas? (Please circle all that apply.)

Blurred distance vision blurred near vision night vision problems decreased side vision
double vision eye discomfort or pain redness scratchy or sandy feeling itching burning
mucous or mattering excess tearing or watering light sensitivity spots floating in vision flashing lights

Are you interested in contact lenses? YES NO MAYBE

Are there any other concerns you would like to have addressed?

_____
_____
_____

REFERENCE

How did you find out about your clinic? Internet Doctor Friend/Family Other: _____

Name of person who referred you if possible: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of the Notice of Privacy Practices

Patient name _____ **Parent or guardian (if minor) _____**
PLEASE PRINT PLEASE PRINT

Patient Signature _____ **Date _____**

Contact Release Information

I agree to permit Meador Eye Clinic and their business associates to contact me, and all other responsible parties on my account, on our cell phone or mobile devices concerning any and all aspects of my account. _____(Patient or Legal guardian signature)

INSURANCE INFORMATION

Name of **Primary Medical** Insurance _____
Insurance ID _____
Name of Insured _____ DOB of Insured_____
Insured's Address (if different than patient) _____
_____
Insured's Place of Employment _____

Name of **Secondary Medical** Insurance _____
Insurance ID _____
Name of Insured _____ DOB of Insured_____
Insured's Address (if different than patient) _____
_____
Insured's Place of Employment _____

Name of **Primary Vision** Insurance _____
Insurance ID _____
Name of Insured _____ DOB of Insured_____
Insured's Address (if different than patient) _____
_____
Insured's Place of Employment _____

Name of **Secondary Vision** Insurance _____
Insurance ID _____
Name of Insured _____ DOB of Insured_____
Insured's Address (if different than patient) _____
_____
Insured's Place of Employment _____

INSURANCE SIGNATURE ON FILE

I authorize my doctor to act as my agent in helping me to obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to *Family Eye Clinic* on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency, and authorizes my doctor to act as my agent.

_____ PATIENT SIGNATURE