MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date of Birth _____

Referring Doctor _____ Primary Care Physician _____

Do you wear glasses? _____ If yes, please circle:

DISTANCE READING PROGRESSIVE BIFOCAL/TRIFOCAL

OTHER: _____

Do you wear contact lenses? _____ If yes, what type? _____

Do you have any history of eye problems or disease?_____ If yes, please circle:

CATARACTS RETINAL DISORDER CORNEAL PROBLEMS

MACULAR DEGENERATION CROSS-EYE OR LAZY EYE GLAUCOMA

DIABETIC EYE DISEASE OTHER _____

Please list any illnesses, injuries, surgeries and hospitalizations you have had:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list all medications (including eye drops and medications) you are taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? _____ If so, please list:_____

_____

SEE BACK

We are concerned about your **general health** as problems elsewhere in the body may affect the health of your eyes and vision. Do you currently have any of the following problems:

	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear, nose, mouth or throat problems	☐	☐	_____
Breathing problems, emphysema, bronchitis, asthma	☐	☐	_____
High blood pressure, heart disease	☐	☐	_____
Rashes, excessive dry skin	☐	☐	_____
Stomach problems, abdominal pain, heartburn, diarrhea	☐	☐	_____
Urinary problems, prostate problems	☐	☐	_____
Arthritis, muscle aches, joint pain, swollen joints	☐	☐	_____
Diabetes, thyroid problems	☐	☐	_____
Allergies	☐	☐	_____
Depression, anxiety	☐	☐	_____
Neurologic (multiple sclerosis, Parkinson's, Alzheimer's)	☐	☐	_____

Family History (please circle any that apply and their relationship to you)

Cancer
High Blood Pressure
Heart Disease
Diabetes
Stroke
Kidney Disease
Glaucoma
Macular Degeneration
Cross-eye or Lazy Eye
Retinal Disorders
Blindness

Social History:

Marital Status: Single Married Widowed Divorced

Occupation: _____

Do you use tobacco? Yes ☐ No ☐

Patient signature: _____ Date: _____

Reviewed by: _____ Date: _____

MAY EYE CARE, INC.

Patient's Last Name First Name M.I.	Marital Status S/ M/ W/ D/ SEP	Date of Birth	Sex F / M	Social Security #

Permanent Address (Street) (Unit #)	City	State	Zip

Home Phone Number	Work Phone Number	Primary Care Physician

If patient's under 18 years of age – Parent/Guardian's Name	Soc. Sec. #	Date of Birth

Patient's Employer	Occupation (indicate if student)	

Employer's Address

Spouse's Name	Spouse's Date of Birth	Spouse's Work Phone Number

Spouse's Employer	Address

Nearest Friend or Relative Other Than Above	Address	Phone

With whom may we discuss your eye care treatment? (Example: Name of spouse, children, etc…)

INSURANCE INFORMATION:

Person Responsible for Payment	Address	Phone

Insurance Company's Name – Primary	ID Number	Group Number	Effective Date

Subscriber's Name	Place of Employment	Subscriber's Date of Birth

Insurance Company's Name – Secondary	ID Number	Group Number	Effective Date

Worker's Compensation:			
Were you injured on the job	Date of Injury?	Was Employer Notified?	Who was Notified?

All fees for professional services rendered are the patient's responsibility. This office will provide direct billing to participating insurance companies. Payment is expected on the date of service for all non-reimbursable fees unless prior arrangements have been made.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE MAY EYE CARE, INC. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN (S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENT OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Signature_____ Date_____