Medical History Questionnaire

Name: _____ Today's Date: _____

Reason for Today's Visit (Please check all that apply.)

❑ Eye Health ❑ Contact Lenses ❑ Glasses ❑ Vision Problem
❑ Eye Infection ❑ New Condition ❑ Existing Condition ❑ Surgery Consultation

Please Explain: _____

_____

Date of Birth: _____ Last 4 of SSN: _____

Address: _____ City: _____ Zip Code: _____

Preferred Phone #: _____ Please circle: Cell Home Work

Alternate Phone #: _____ Please circle: Cell Home Work

Email: _____ Occupation: _____

Medical Insurance: _____ Member ID #: _____

Vision Insurance: _____ Member ID #: _____

Date of Last Eye Exam: _____ Primary Care Provider: _____

Medical History:

Do you take any medications? ❑ No ❑ Yes (If yes, please include oral contraceptives, over the counter medications, aspirin, and supplements.) ***If you have a list of medications with you or a photo on your phone, we can take a copy.***

_____

_____

_____

Do you have any allergies to medications? ❑ No ❑ Yes If yes, please explain: _____

_____

List all major injuries, surgeries, and medical conditions: _____

_____

Check any of the following that you have had: ❑ dry eyes ❑ cataracts ❑ glaucoma ❑ crossed eyes
❑ floaters ❑ retinal disease/detachment ❑ macular degeneration ❑ eye injury ❑ eye surgery

Are you pregnant or nursing? ❑ Yes ❑ No

Do you wear glasses? ❑ Yes ❑ No If yes, how old is your present pair? _____

Do you wear contact lenses? ❑ Yes ❑ No If yes, how old is your present pair? _____

Type of contact lenses: ❑ Soft ❑ Rigid Are they comfortable? ❑ Yes ❑ No

Family History: Please notate parents, grandparents, sibling, or children for the following conditions.

Disease/Condition	No	Yes	?	Relationship to you
Blindness	❑	❑	❑	
Cataract	❑	❑	❑	
Crossed Eyes	❑	❑	❑	
Glaucoma	❑	❑	❑	
Arthritis	❑	❑	❑	
Macular Degeneration	❑	❑	❑	
Retinal Disease	❑	❑	❑	

Disease/Condition	No	Yes	?	Relationship to you
Cancer	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
High Blood Pressure	❑	❑	❑	
Thyroid Disease	❑	❑	❑	
Autoimmune Disease	❑	❑	❑	
Other				

Please complete second page

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	?
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary (Skin)	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection, Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid/Other Glands	☐	☐	☐

System	NO	YES	?
Ears, Nose, Mouth, Throat			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular / Cardiovascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Genitals/Kidney/Bladder	☐	☐	☐
Bones / Joints / Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic / Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Allergic / Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

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

_____

_____

_____

_____

_____ _____

Doctor's Signature Date

HIPAA Privacy Act / Release Form

Name: _____ Date: _____

Date of Birth: _____

( ) I authorize my information to be released to the following:

_____

_____

( ) Do not release my information to anyone.

_____

( ) I understand that Bradford Vision Center follows the HIPAA Privacy Act and I understand that a copy of this is available upon my request.

The authorization to share my information is valid for all past, present and future periods. I understand that I am permitted to revoke this authorization during any time. I understand that in the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel my permission to share my health data. I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or individual please complete sections below.

Name: _____ Signature: _____

Relationship to Patient: _____

Please complete the back side

Medical Vs. Vision Insurance

One of the most challenging issues in an eye office is determining whether an exam should be billed to the medical or vision plan.

For Patients with Both Medical and Vision Coverage

Your vision insurance is intended to provide you with routine care and a refractive exam. If you are being evaluated for medical reasons (corneal disorders, diabetes, cataracts, glaucoma suspect, dry eye, etc.) you are being provided with medical care that is more time consuming and places greater liability on the treating physician. Typically vision insurance does not provide coverage for medical care. Therefore, we will file a claim with your medical insurance plan, your exam will be filed as a secondary claim to your vision plan after medical plan completes the claim. Anyone with these conditions can receive an undilated exam and refraction and this can be billed to the vision insurance only and a dilated exam could be scheduled on another day. Annual dilated eye examinations are strongly recommended to monitor retinal cataracts, diabetes, macular degeneration and other eye diseases and often help in detecting unknown conditions. The dilated portion of the exam and follow up visits to monitor these conditions would be billed to the medical insurance. Deductibles, copays and co insurance costs that are involved can be looked up upon request before services are provided

For Patients without vision coverage

If you are being seen for a routine eye exam and do not have vision coverage, your medical insurance will not pay for the exam. However, if you have a medical problem like the ones listed above, then your medical insurance could cover part or all of the exam. Medicare and some other medical insurances do not cover the refractive (vision testing) exam, but these insurances could cover other parts of the exam and reduce cost of this service to $25. If your medical insurance doesn't cover any part of the exam, then the maximum rate for an undilated exam will be $65. The cost of a dilated eye exam is more difficult to predict as some eye conditions can't be detected until the pupil is larger.

We are happy to assist in any way we can in answering questions for clarifying information regarding this topic as we understand the confusion. Sign below acknowledging the receipt of this information.

_____ _____

Signature Date

_____

Print Name

Please complete the back side