

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Exam Date _____
 Date of Last medical Exam _____ Date of last eye exam _____
 Your Medical Doctor's name _____ Last Eye Doctor's Name _____
 List any **medications** you currently take (Rx and over-the-counter): _____

Do you have **allergies** to any medications? YES NO If YES, please list: _____

List any **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.) _____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you **currently** have any problems in the following areas? If YES, please provide additional information.

	Yes	No	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat, stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO
 Have you ever had a blood transfusion? YES NO
 Do you drink alcohol? YES NO If YES, how much? _____
 Do you smoke? YES NO If YES, how much? _____ How many years? _____

Physician's Signature _____ Date _____

PATIENT MEDICAL INFORMATION

Last Name: First Name: MI: Exam Date
Name of Parent or Guardian if Patient is under 18 years old:
Address: City: State: Zip
Home Phone: Work Phone: Cell Phone:
SS# Birth Date Married: Yes No
Patient Occupation Hobbies/Activities:

Who can we thank for referring you to our office?

Insurance Carrier: Insured's name:
Insured's Employer: Patient's Relationship to Insured: Self Spouse Child Other
Insured's ID Number Insured's Birth Date:

Reason for today's visit:

INSURANCE AUTHORIZATION

I request that payment of authorized insurance benefits for any services furnished me, be made on my behalf to: Taylor Eye Associated, PLLC.

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

X Signature of Patient or Parent or Guardian Date:

Please do not sign the two sections below until you received the information at your appointment.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I reviewed or received a copy of the Notice of Privacy Practices for this office.

X Signature of Patient or Parent or Guardian Date:

SCREENING RETINAL PHOTOGRAPHY

YES, I want the Screening Retinal Photography. The fee is \$35 and is not covered by insurance.

NO, I do not want the Screening Retinal Photography.

X Signature of Patient or Parent or Guardian Date: