Patient History Questionnaire

Date_____

Last: _____ **First:**_____ **MI** ____ **Nickname**_____

Address_____ **DOB** ___/___/____ **SSN** ___-___-_____

_____ **Birth Sex F M Decline to specify**

City _____ **State**____ **Zip** _____ **Email** _____

Cell _____-_____-_____ **Work** _____-_____-_____ **Home** _____-_____-_____

Occupation _____ **Computer Usage**_____

Special Needs_____ **Sports/Hobbies**_____

Parent/guardian_____ **Family Doctor** _____

Last Eye Exam_____ **Dr. Phone** _____-_____-_____

Last Medical Exam _____ **Alt. Contact** _____ **Phone** _____-_____-_____

Note: **For dates where exact date is unknown, please use a number that is as close as you can remember.**

Only check Yes to those items you are experiencing or think you might be.
You don't NEED to check NO!

Review of Systems

CONSTITUTIONAL

Fever	___ Y ___ N ___ ?
Weight gain/loss	___ Y ___ N ___ ?

INTEGUMENTARY

Skin	___ Y ___ N ___ ?

NEUROLOGICAL

Headaches	___ Y ___ N ___ ?
Migraines	___ Y ___ N ___ ?
Seizures	___ Y ___ N ___ ?

EARS/ NOSE/ THROAT

Allergies/ hay fever	___ Y ___ N ___ ?
Sinus congestion	___ Y ___ N ___ ?
Runny nose	___ Y ___ N ___ ?
Post-nasal drip	___ Y ___ N ___ ?
Chronic cough	___ Y ___ N ___ ?
Dry throat/mouth	___ Y ___ N ___ ?
Ringing in ears	___ Y ___ N ___ ?
Ear pain or infection	___ Y ___ N ___ ?
Hearing aids	___ Y ___ N ___ ?
Deaf	___ Y ___ N ___ ?

GASTROINTESTINAL

Diarrhea	___ Y ___ N ___ ?
Constipation	___ Y ___ N ___ ?

EYES

Loss of vision	___ Y ___ N ___ ?
Blurred vision	___ Y ___ N ___ ?
Distorted vision/halos	___ Y ___ N ___ ?
Loss of side vision	___ Y ___ N ___ ?
Double vision	___ Y ___ N ___ ?
Dryness	___ Y ___ N ___ ?
Mucous discharge	___ Y ___ N ___ ?
Redness	___ Y ___ N ___ ?
Itching	___ Y ___ N ___ ?
Burning	___ Y ___ N ___ ?
Foreign body sensation	___ Y ___ N ___ ?
Excess tearing	___ Y ___ N ___ ?
Glare/light sensitivity	___ Y ___ N ___ ?
Eye pain/soreness	___ Y ___ N ___ ?
Chronic infection eye/lid	___ Y ___ N ___ ?
Styes or chalazion	___ Y ___ N ___ ?
Flashing lights	___ Y ___ N ___ ?
Floaters in vision	___ Y ___ N ___ ?
Tired eyes	___ Y ___ N ___ ?
Color blind	___ Y ___ N ___ ?

VASULAR/CARDIOVASCULAR

Diabetes ___Y ___N ___?
Heart disease ___Y ___N ___?
High blood pressure ___Y ___N ___?
High cholesterol ___Y ___N ___?

GENITOURINARY ___Y ___N ___?

Gonads/Kidneys/Bladder ___Y ___N ___?

LYMPHATIC/HEMATOLOGICAL

Anemia ___Y ___N ___?
Bleeding problems ___Y ___N ___?

BONES/JOINTS/MUSCLES

Rhemumatoid arthritis ___Y ___N ___?
Other arthritis ___Y ___N ___?
Muscle pain ___Y ___N ___?
Joint pain ___Y ___N ___?

ENDOCRINE

Thyroid/other glands ___Y ___N ___?

PSYCHIATRIC ___Y ___N ___?

ALLERGIC/IMMUNOLOGIC ___Y ___N ___?

If you answered * ? * to any of the above or have a condition not listed please explain.

FAMILY HISTORY

Please note any family history (parents,grandparents, siblings, children, living or deceased) for the follwing conditions

DISEASE/CONDITIONS		RELATIONSHIP
Blindness	___Y ___N ___?	_____
Cataracts	___Y ___N ___?	_____
Glaucoma	___Y ___N ___?	_____
Crossed eyes	___Y ___N ___?	_____
Macular degeneration	___Y ___N ___?	_____
Retinal detachment/disease	___Y ___N ___?	_____
Arthritis	___Y ___N ___?	_____
Cancer	___Y ___N ___?	_____
Diabetes	___Y ___N ___?	_____
Heart disease	___Y ___N ___?	_____
High blood pressure	___Y ___N ___?	_____
High cholesterol	___Y ___N ___?	_____
Kidney disease	___Y ___N ___?	_____
Lupus	___Y ___N ___?	_____
Thyroid disease	___Y ___N ___?	_____
Asthma	___Y ___N ___?	_____
Other	___Y ___N ___?	_____

If other , explain _____

MEDICAL HISTORY

Do you have any allergies to medication? ____YES ____NO

If yes, Explain _____

List any medication you take (including oral conterceptives, asprin, over the counter medication & home remedies

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

List any of the following that you have had:

Prominent eyes	___Y___N	Eye injury	___Y___N
Eye infection	___Y___N	Lazy eye	___Y___N
Cataracts	___Y___N	Glaucoma	___Y___N
Crossed eyes	___Y___N	Drooping eyes	___Y___N
Retinal disease	___Y___N		

Do you wear glasses ___Y___N If yes, how old is your present pair of glasses? _____ Years

Do you wear contacts ___Y___N If yes, how old is your present pair of lenses? _____ Weeks

Type of contact Lenses: ___ Rigid ___ Soft ___Extended wear ___Dailies ___Other

Are they confortable ? ___Y___N

Are you pregnant? ___Y___N

SOCIAL HISTORY

This information is kept strictly confidential. However you may dicuss this portion directly with the doctor.

____YES I would prefer to discuss my social history information directly with my doctor.

Do you Drive? ___YES ___NO If yes, do you have any visual diffculty when driving? ___YES___NO

If yes, please describe _____

DO YOU USE:

Tobacco products ? ___Y___N If yes, type/amount/how long?

_____

Alcohol? ___Y___N If yes, type/amount/how long?

_____

Illegal drugs? ___Y___N If yes, type/amount/how long?

_____

Have you ever been exposed to or infected with :

Gonorrhea	__y ___ N __?	Hepatitis	__y ___ N __?
Syphillis	__y ___ N __?	HIV/AIDS	__y ___ N __?

Whom may we thank for referring you ?

_____

INSURANCE INFORMATION

We expect payment at the time of service unless you are in a plan in which we receive reimbursement. We will provide you with a coded insurance receipt.

PLEASE PRESENT ALL INSURANCE CARDS FOR COPYING

PRIMARY INSURANCE

Insurance Company: _____

Member's Name: _____ DOB: _____

ID Number: _____ Group: _____

Employer: _____

SECONDARY INSURANCE/VISION INSURANCE

Insurance Company: _____

Member's Name: _____ DOB: _____

ID Number: _____ Group: _____

Employer: _____

Responsible party if other than patient

Name_____Relationship to patient _____

Mailing Address _____

Home Phone _____ DOB _____ SSN _____

Employer _____

Employer Address _____

Work phone _____

Medical Lifetime Signature on File: I authorize payment of Medicare benefits to Dr. Meredith Bomse for services rendered to me. I authorize release of medical information about me to the Health Care Financing Administration to determine benefits.

SIGNATURE:_____ DATE: _____

FINANCIAL AGREEMENT: I authorize payment of any insurance benefits for unpaid services to Meredith Bomse, OD and I am responsible for any balances after insurance claims have been paid. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Dr. Bomse. In the absence of insurance, I agree that in return for the services provided by Dr. Bomse, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Dr. Bomse for payment. I understand and agree if my account is delinquent, I may be sent to collections.

SIGNATURE:_____ DATE: _____

MEDICAL VS VISION INSURANCE

Vision insurance is intended to provide you with a baseline eye evaluation. It generally covers diagnoses that are treatable with glasses and/or contact lenses.

If you are being seen for a "routine" eye evaluation, your vision insurance will be billed. Your medical insurance will not pay for your eye exam.

Medical Insurance is for visits related to medical complaints and problems. If you are being evaluated for a medical reason (cornea disorder, diabetes, cataracts, glaucoma suspect, allergies, dry eyes, ect.), you are being provided with medical care. Therefore, your medical insurance will be billed. Your vision insurance does not provide for medical care. Also, please be aware that many medical plans will no longer pay for eye exams with a diagnosis of blurred vision or headache. They are considering this a routine vision exam and after will not pay for the visit.

Our billing speciallist will determine appropriate billing after your evaluation.

_____ _____

Signature **Date**