MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____ Age: _____ Date:_____

Sex: Male / Female Primary Care Physician: _____

CONDITIONS:	Circle any and all conditions that apply to you or check none.	NONE
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches, other _____	☐
EARS, NOSE, THROAT:	hard of hearing, earache, cough, dry mouth, sinus, allergy, hoarseness, vertigo, tinnitus, other _____	☐
CARDIOVASCULAR:	high B/P, heart attack, chest pain, congestive heart failure, racing pulse, high cholesterol, irregular heartbeat, palpitations, pace maker, murmur, a-fib, other _____	☐
RESPIRATORY:	congestion, wheezing, short of breath, asthma, COPD, emphysema, other _____	☐
GASTROINTESTINAL:	stomach upset, diarrhea, constipation, hernia, ulcers, nausea, GERD, Crohn's disease, other _____	☐
GENITOURINARY:	painful/ frequent urination, impotence, incontinence, jaundice, kidney stones, blood in urine, other _____	☐
FEMALES:	Are you pregnant?_____ Are you nursing?_____	☐
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis, other _____	☐
DERMATOLOGIC:	acne, psoriasis, eczema, warts, growths, skin rash, rosacea, skin cancer: type _____; other _____	☐
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, dementia, memory loss, Alzheimer's, Parkinson's, ADHD , other _____	☐
PSYCHIATRIC:	anxiety, depression, schizophrenia, other _____	☐
ENDOCRINE:	diabetes: type I, type II; hypothyroid, hyperthyroid, Graves disease, thyroid eye disease, hypoglycemia, postmenopausal, hepatitis other _____	☐
HEMATOLOGY:	bleeding, anemia, blood clots, other _____	☐
ALLERGIC/IMMUNOLOGIC:	sinus, seasonal allergies, swelling, redness, itching, hives, lupus, HIV, herpes simplex virus, Sjogren's syndrome, rheumatoid arthritis, multiple sclerosis , other _____	☐
CANCER:	leukemia, breast, prostate, lung, skin, colon, skin, other _____	☐
EYES:	dry eye, punctal plugs, cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration, double vision, other _____	☐

List all Eye Surgeries & Laser Eye Surgeries:

_____

_____

List all other relevant surgeries you have had:

_____

_____

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition			Family Member	Disease/Condition			Family Member
Lazy Eye	yes	no	Mother Father Sibling Grandparent	Heart Disease	yes	no	Mother Father Sibling Grandparent
Macular Degeneration	yes	no	Mother Father Sibling Grandparent	Hypertension	yes	no	Mother Father Sibling Grandparent
Blindness	yes	no	Mother Father Sibling Grandparent	Stroke	yes	no	Mother Father Sibling Grandparent
Retinal Disorders	yes	no	Mother Father Sibling Grandparent	Thyroid Disease	yes	no	Mother Father Sibling Grandparent
Cataracts	yes	no	Mother Father Sibling Grandparent	Arthritis	yes	no	Mother Father Sibling Grandparent
Glaucoma	yes	no	Mother Father Sibling Grandparent	Cancer	yes	no	Mother Father Sibling Grandparent
Diabetes	yes	no	Mother Father Sibling Grandparent	Type of Cancer: _____			

MEDICAL HISTORY QUESTIONNAIRE

Patient Name:________________________________Date of Birth:_______________Date:______________

SOCIAL HISTORY: Please circle what applies

Employment Status:	**Marriage Status:**	**Tobacco Use:**	**Alcohol Consumption:**
Student	Single	Current Every Day Smoker	Never
Homemaker	Married	Current Some Day Smoker	Occasionally
Employed	Separated	Heavy Smoker	Daily
Retired	Divorced	Light Smoker	Heavily
	Widowed	Never Smoker	
		Former Smoker	

DO YOU HAVE ANY DRUG ALLERGIES? ☐ Yes ☐ No **If yes, please list** ____________________________

DO YOU TAKE ANY MEDICATIONS? ☐ Yes ☐ No **(If you checked yes, please list medications below)**

List all Prescriptions and Over the Counter medications you are taking: (Including eye drops, aspirin and ibuprofen)

If you have a list, please give to receptionist to copy in lieu of filling out form: **REVIEWED:**

Medication Name	Dosage	Taken how often? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		___ Times a day ____ or PRN	__ Oral __ Topical __ Injection			

Staff	*Date*

All information you provide is confidential and will not be released to anyone without your consent. Use back of this form for any additional information that you need to add.

PATIENT INFORMATION (PLEASE PRINT)

Name _____ Date of Birth _____/_____/_____

Address _____

City _____ State _____ Zip _____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

M/F _____ My primary phone number is Home Cell (circle preference)

Email Address: _____

Employer / If child, parent's employer _____ Occupation _____

Work Address _____

Spouse Name _____ Employer _____

Work Address _____

Your Primary Physician _____ Your Cardiologist _____

Pharmacy _____ Phone number/and/or address _____

Referred by: Friend/Relative _____ Doctor _____

If you are seeing Dr. Fountain, who is your general ophthalmologist? _____

Are you personally responsible for the payment of your fees? _____ Yes _____ No

If no, who is? _____ Relationship _____

Primary Insurance _____ Secondary Insurance _____

Name of Policy Holder _____

Policy Holder Date of Birth _____ /_____ /_____

PLEASE MAKE SURE THE FRONT DESK HAS A COPY OF YOUR CURRENT MEDICAL INSURANCE CARD(S) AND REFERRAL IF REQUIRED.

(WE ARE NOT ON ANY VISION PLANS.)

(Please note that you have the option to decline to answer these questions.)

Race: ❑ African-American ❑ American Indian ❑ Asian ❑ Caucasian ❑ Native Hawaiian ❑ Unknown ❑ Other Race

Preferred Language: _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Unknown

Please fill in the information below if your appointment is related to an injury that occured at work:

Workplace: _____ Occupation: _____

Workman's Comp Contact Person: _____

Address: _____ Phone Number: _____

Notice of Privacy Practices Acknowledgement/Phone Message and Contact Authorization

Patient Name _____ **Date of Birth:** _____

The **Notice of Privacy Practice (NPP)** tells you how we may use and share your health records. It also describes your rights with respect to your health records. **Please read it.**

- We will use and share your health records to treat you and to bill you for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required/allowed by law.

I understand that the NPP is available at the front desk of Ophthalmology Partners, Ltd.
I acknowledge receipt of the Notice of Privacy Practices (NPP).

Signature of Patient: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Name of Authorized Representative: _____ Relationship: _____

Phone Message and Contact Authorization: Please CHECK the appropriate answer below:

Do the physicians and staff of Ophthalmology Partners, Ltd. have your permission to leave messages containing medical and/or financial information on your **answering machine?**

At home	☐ **Yes**	☐ **No ***
At work	☐ **Yes**	☐ **No ***
On cell	☐ **Yes**	☐ **No ***

* IF YOU CHECK "NO", ONLY THE DATE, TIME AND LOCATION OF APPOINTMENTS WILL BE LEFT ON YOUR ANSWERING MACHINE.

The individual(s) named below will also be your emergency contact(s) unless you specify otherwise.
Please complete below: **I give authorization to the doctors and staff of Ophthalmology Partners, Ltd. to discuss my medical and/or financial information with the following people:**

	Name	Relationship	Phone
(1)	_____	_____	_____
(2)	_____	_____	_____
(3)	_____	_____	_____

I understand that it is my responsibility to inform Ophthalmology Partners, Ltd. of any desired changes in this authorization.

Signature: _____ Date: _____

Routine Vs Medical Eye Exam

A medical eye exam produces a diagnosis, like conjunctivitis, dry eye, glaucoma or cataracts, to mention a few. Depending on your policy, your medical insurance may cover a medical exam, but not pay for the exam if it is a routine eye exam.

A routine eye exam is defined by insurance companies as an office visit for the purpose of checking vision, screening for eye disease, and/or updating eyeglass or contact lens prescriptions. Routine eye exams produce a final diagnosis, like nearsightedness, farsightedness or astigmatism. Medicare and many medical insurance policies do not pay for routine vision exams. If your medical insurance does have a benefit for this type of exam please let us know so we can submit it correctly.

All examinations at Ophthalmology Partners, LTD (OPL, LTD) are submitted to your medical insurance. OPL, LTD is not in network for any vision plans (VSP, Davis, etc).

Refraction

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination (whether routine or medical) and required to write a prescription for glasses or contact lenses. At times, it is medically necessary to perform a refraction to help determine the cause of visual changes. This is particularly helpful when patients have multiple issues affecting their eyes such as cataract, glaucoma and macular degeneration. Despite being medically necessary, refractions are still not considered a covered service under most insurance plans.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations. If you have a vision plan, you may be able to submit separately for coverage of your refraction. We are not in network under any vision plans so we are unable to submit for you, but most vision plans have information online of how you can submit yourself and out of network benefits.

Please keep in mind

Insurance coverage doesn't mean payment. Many health plans have copayments and deductibles that must be met before your insurance will pay any amount towards your bill. Check with your insurance carrier prior to your office visit to check your benefits, to confirm that our doctors are classified as providers in your plan, and to determine if refractions or routine visits are covered under your plan. If your policy requires a referral, it is the patient's responsibility to present it at the time of the visit.

Financial Policy

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I understand that I am financially responsible to OPL, LTD for any covered or non-covered services as defined by my insurer. Copays, refraction fees and any cosmetic fees are due at the time of the visit. I understand that if I am billed for over 3 billing cycles a $25 fee will be added to my balance. If my account is referred to a collection agency, a collection fee of 30% of the overdue balance will also be added to the amount due. I understand that I am financially responsible for the added fees to my balance due to payment delinquency.

Signed _____Date_____

(Patient or parent if minor)

Consent for use for visual images

I hereby give permission to Ophthalmology Partners Ltd., (the corporation) to photograph, videotape, or otherwise illustrate my clinical condition and to use this material on paper, film, or in electronic and internet transmission as deemed advisable for diagnostic, therapeutic, educational, or research purposes. I further give permission for the use of this material to illustrate scientific papers, books, or lectures at any time hereafter without inspection or approval, on my part, of the finished product or specific use to which this material may be applied. It is understood that in no way will I be identified by name. I hereby release and hold harmless Ophthalmology Partners Ltd., and all its participating physicians from all claims of liability, loss or expense which may result from activities authorized by this agreement.

Patient_____

Date_____

Consent for electronic communications

In order to give you the best care possible, your doctor may need to communicate with your referring doctor or other doctors about your health care history. Electronic mail is often the most efficient method of communication. We take steps to ensure the confidentiality of your health information but security breaches are always a remote and unlikely possibility. By signing below, you give permission, when necessary, for your doctor, to communicate electronically with other physicians that are part of your health care team in order to coordinate your treatment plan.

Patient_____

Date_____