Eyecare Associates of Wyoming,PC

Medical History Questionnaire

Name_____SocSec#_____

Male ( ) Female ( ) Single ___ Married___ Divorced___ Widowed___

Address_____City_____State_____Zip_____

Home#_____Cell#_____Text Message **Y N**

Date of Birth_____ Age _____ Email_____

Employer(or School)_____Occupation_____

Spouse(Parent)_____Children's names/ages_____

Referred By_____ Last Eye Exam _____

Primary Care Physician and address_____

Last Eye Doctor and Address_____

Reason for this Visit_____

ARE YOU INTERESTED IN No Line Bifocals? Y N Contact Lenses? Y N Laser Vision Correction? Y N

Do you wear Glasses? Y N If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? Y N If yes, how old is your Present pair of lenses? _____

Type of Contact lenses ___ Rigid ___ Soft ___Extended wear ___Other Are they comfortable? Y N

Personal & Family Medical History

Do you have a significant history or have you been treated for:

Cataracts:	__ Self ___ Family	**Eye Surgery:**	__ Self ___ Family
Crossed Eyes:	__Self ___ Family	**Glaucoma:**	__ Self ___ Family
Diabetes:	__ Self ___ Family	**Lazy Eyes**	__ Self ___ Family
Eye Disease:	__ Self ___ Family	**Macular Degeneration:**	__ Self ___ Family
Eye Injury:	__ Self ___ Family	**Retinal Disease:**	__ Self ___ Family

Eye Problems

Loss of Vision	Y N	Blurred Vision	Y N	Double Vision	Y N
Dryness	Y N	Flashes or Floaters	Y N	Itching	Y N
Burning	Y N	Excess Watering	Y N	Tired Eyes	Y N
Eye Pain or Soreness	Y N	Redness	Y N		

Medical Conditions

Heart problems	Y N	Arthritis	Y N	High Blood Pressure	Y N
Vascular Disease	Y N	Anemia, other	Y N	Asthma	Y N
Emphysema	Y N	Kidney disease	Y N	Allergies/Hay Fever	Y N
Intestinal disease	Y N	Anxiety	Y N	Headaches	Y N
Depression	Y N	Insomnia	Y N	Migraines	Y N
Seizures	Y N	Cancer	Y N	Thyroid problems	Y N
High Cholesterol	Y N	Other Major Illness	Y N		

If you answered **YES** to any of the above or have a condition not listed, Please explain:

_____

_____

Please turn over and complete side two

Medical History

Do you have any **allergies to Medications**? NO YES if yes, explain_____

_____

List any Medications (including Birth Control & over the counter medications)

_____

_____

List **Any Surgeries** you have had_____

_____

Social History

Do you smoke? (Please circle one) **None Social Moderate Heavy**

Number of years smoked? _____ Number of years stopped if former smoker _____

Do you Drink alcohol? (Please circle one) **None Social Moderate**

Any History of STD's? Y N Do you have HIV/Hepatitis? Y N Are you Pregnant or Nursing? Y N

Are you taking any Hormones (BC)? Y N

Have you had a blood transfusion? Y N if yes, when and where_____

Do you use a computer? Y N If yes, how many hours per day? _____

INSURANCE INFORMATION:

Vision Insurance Name _____ ID#_____Group#_____

Member Name_____SS#_____Birth date_____

Relationship to patient_____ Member Employer_____

Medical Insurance Name_____ID#_____Group#_____

Member Name_____Member Employer_____

Member birthdate_____ Relationship to patient_____

(We will Courtesy submit to your insurance)

RESPONSIBLE PARTY:

Name :_____**Address:**_____**Phone:**_____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I understand and agree that (regardless of my insurance status) I am ultimately responsible to pay all fee and charges for treatment of the person named above. I agree to pay all charges for me and all members of my family when services are rendered.

HIPPA Privacy Acknowledgment of Receipt of Notice of Privacy Practice:

I,_____ **[Please print full legal name here], have been presented with the Notice of Privacy Policy (the "Policy") of Eyecare Associates of Wyoming, and have been offered a copy to keep for my records.**

Signature_____**Date**_____

ALL PAYMENTS ARE DUE ON DATE OF SERVICE