

Medical History Questionnaire



Name _____
Goes By: _____
Gender: M / F
Address _____
City _____ State _____ Zip _____
Home Phone: _____
Cell Phone: _____
Email _____

Date of Birth _____
Social Sec. Number _____
Marital Status _____
Employer _____
Full time / Part time
Occupation _____
How did you hear about us _____

Insurance Information

Please alert the front desk if you have more than one medical insurance.

Name of Medical Insurance: _____ Member ID: _____

Primary's Name (Last, First Middle): _____

Primary's Date of Birth: ____/____/____ Gender: M / F Primary's SSN: _____ - _____ - _____

Name of Vision Insurance: _____

Member ID (if different from SSN): _____

Examination Information

Last Medical Exam: _____ Name of Doctor: _____

Last Eye Exam: _____ Name of Doctor: _____

Reason for today's Exam: Vision Blur Eye Pain/Discomfort Lasik Pre/Post Op. Failed Screening
 Headache Flashes/Floaters Cataract Pre/Post Op. Annual Eye Exam
 Other: _____

Medical History

Do you currently have any of the following conditions:

AIDS Keratoconus Sarcoidosis
 Asthma Hypertension Seizures
 Cancer _____ (Type) Hyperthyroid Sjogren's Syndrome
 High Cholesterol Marfan's Syndrome Steven-Johnson's Syndrome
 Diabetes Migraine Headaches Other _____

Systemic Medications:

Please list all medication that you take, including OTC and Naturopathic Remedies: _____

Ocular History:

Do you have or had any of the following conditions:

- | | | |
|---|---|---|
| <input type="checkbox"/> Ocular Allergies | <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Prosthetic Eye |
| <input type="checkbox"/> Amblyopia (Lazy Eye) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> LASIK/PRK/RK | |
| <input type="checkbox"/> Corneal Ulcer | <input type="checkbox"/> Macular Degeneration | |

Ocular Medications:

Please List all ocular medications that you take, including Artificial Tears or Visine: _____

Social History

Please note that this information is kept strictly confidential.

- | | | |
|--|----------------------------------|--|
| Do you use Tobacco? | Do you use Alcohol? | |
| <input type="checkbox"/> No | <input type="checkbox"/> No | <input type="checkbox"/> Above Average |
| <input type="checkbox"/> Yes, Number of packs a day? _____. | <input type="checkbox"/> Social | <input type="checkbox"/> Dependent |
| <input type="checkbox"/> Former smoker. Number of years _____. | <input type="checkbox"/> Average | |

Do you use any Recreational Drugs? Yes No I prefer to discuss this privately with the Doctor.

Family History

Please check the box if anyone in your family has or has had any of the following:

	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinitis Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown Vision Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (What kind?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Unknown: Adopted

Glasses and Contact Information

Do you wear Glasses? No Yes
 If so, are they for: Distance Only Reading Only Computer Distance and Near

Do you wear Contacts? No Yes
 If so, what brand are they? _____

Are you interested in wearing contacts? No Yes

Review of Systems

Please list any medications that you are allergic to: _____

Please list any environmental allergies you have: _____

Do you currently, or have you ever had any problems in the following areas: (if yes, please circle)

Cardiovascular

Angina
High Cholesterol
Hypertension
Myocardial Infarction (Heart Attack)
Stroke
Chest Pain

Constitutional

Appetite Loss
Dizziness
Weight Loss
Weight Gain

Cranial/Facial

Chronic Cough
Dry Mouth
Headaches
Hearing Loss
Sinusitis

Endocrine

Crohn's Disease
Diabetes
Diabetic Suspect
Hyperthyroid
Hypothyroid

Gastrointestinal

Colitis
Gall Stones
Hepatitis
Ulcer

Genitourinary

Kidney Stones
Prostate Disorder

Hematologic/Lymphatic

Anemia
Coagulative Disorder
Sickel Cell Disorder

Immunologic

AIDS
Herpes Zoster (Shingles)
Histoplasmosis
Sarcoidosis
Sjogren 's syndrome
Steven-Johnson's Syndrome

Integumentary

Lupus
Psoriasis
Eczema

Musculoskeletal

Arthritis
Rheumatoid Arthritis
Marfan's Syndrome
Muscular Dystrophy
Myasthenia Gravis

Neurological

Bell's Palsy
Brain Tumor
Dyslexia
Epilepsy
Multiple Sclerosis
Neurofibromatosis
Sturge-Weber Syndrome

Psychiatric

Attention Deficit Disorder
Anxiety
Insomnia

Respiratory

Asthma
COPD
Cystic Fibrosis
Emphysema
Tuberculosis

Please check what level of treatment explanation that you would like.

- Tell me everything.
- Give me the basics.
- None. Just fix it.

Records Release

I permit Huffman Family Eye Care to release my diagnosis, treatment plans, including glasses or contacts for refractive diagnosis, and/or medical documentation to the following people.

- Spouse Only
- Immediate Family Members (We can leave a message on your home phone)
- Only directly to me. (This prohibits us from leaving voice messages on anything other than your personal cell phone and dispensing glasses or contacts to anyone other than you in person)

In the event that the patient is a minor with divorced parents, the legal guardian is the only parent permitted to have access to the child's medical records unless otherwise specified by the guardian. If this applies to your situation please verbally inform the front desk when this form is completed or at the time of the child's exam.

Latest Technology Options Available

Retinal Photography: With the improvements of digital photography we can now acquire very detailed photos of the retina instantly. Using this technology, we can now detect many retinal conditions such as, Diabetes, Macular Degeneration and Glaucoma more accurately than with dilation and will minimize the need for dilation.

Optic Nerve Imaging: This procedure measures the thickness of one of the seven layers of the retina around the optic nerve. It has been shown that glaucoma slowly damages this layer and this damage can be measured by the thinning of this layer. Glaucoma can be detected with this procedure 4 to 6 years ahead of conventional methods

Visual Field Analyzer: This procedure will test your peripheral vision where many diseases of the brain such as, pituitary tumors, optic nerve disease and Retinal disturbances due to vascular problems and medications can be detected.

Dr Huffman Highly recommends all three of these tests not only for disease detection but also to establish a baseline to compare all future testing. If all three procedures are chosen to be performed, then the price will be reduced to **\$49**

Retinal Photography	This procedure's fee is \$20	<input type="checkbox"/> I accept	<input type="checkbox"/> I decline this procedure
Optic Nerve Imaging	This procedure's fee is \$20	<input type="checkbox"/> I accept	<input type="checkbox"/> I decline this procedure
Visual Field Analyzer	This procedure's fee is \$20	<input type="checkbox"/> I accept	<input type="checkbox"/> I decline this procedure

I accept all three tests for \$49

Patient Signature: _____ Date: _____

Patient Agreement of Financial Responsibility and Consent to Treat

- Payment for annual deductible and co-insurance are collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company. If I do not give necessary information to process my health/vision insurance in a timely manner, I will be responsible for those charges.
- I acknowledge that if I receive a contact lens exam and do not return within three months of the original exam for my fit and follow up I will be charged for my fit a second time and it will not be billed to my insurance company.
- I have been made aware that there are no refunds given, for any materials, after the 30 day manufacturer's warranty expires, and no refunds are given for any rendered services.
- I voluntarily consent to such care and treatment as prescribed by the doctor as is necessary in his medical judgment.

I fully understand and accept the terms of this Agreement and Consent

Signature _____ Date: _____