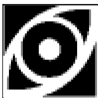


Clarkson Eyecare

PATIENT HISTORY QUESTIONNAIRE

(completion required at each patient appointment)

Welcome to our office

Title ( ) Last name ______________ First name ______________ MI ______ Date ______
(Mr., Mrs., Ms., Miss, Dr.)

Name you wish to be called ______________ E-Mail ______________

Home Address ______________ City ______________ State ______ Zip ______

Age ______ Birthdate ______ SSN ______

Employer/School ______________ Occupation ______________

Name of Parent, Legal Guardian or Spouse ______________

Name of family members whom we have provided care ______________

Insurance Company ______________ ID# ______________

Subscriber name ______________ Relationship to patient ______________

Referred By ______________
(Please mark preferred)

Cell ______________

Home ______________

Work ______________

Subscriber Birthdate ______________

Race (Optional):

American Indian or Alaskan Native   Asian   Black or African American

Native Hawaiian or Other Pacific Islander   White or Caucasian

Ethnicity (Optional):

Hispanic or Latino

Not Hispanic or Latino

Preferred Language: ______________

Medical History / Review of Systems:

List any medications you are now taking (including eye drops, birth control pills, vitamins or over the counter medications):

____

____

Are you allergic to any medications?   Yes   No   Please list: ______________

Primary Care Physician: ______________ Pediatrician: ______________

Preferred Pharmacy: ______________ Location: ______________ Phone: ______________

Do you have or have you ever had any of the following problems:

No   Yes   Asthma/COPD
No   Yes   Diabetes
No   Yes   High Blood Pressure
No   Yes   High Cholesterol
No   Yes   Thyroid Problems
No   Yes   Arthritis
No   Yes   Chronic fever, unexpected weight loss/gain, fatigue
No   Yes   Ear/nose/throat (hearing loss, sinus)
No   Yes   Endocrine Problems
No   Yes   Gastrointestinal Problems (ulcer, abdominal pain, diarrhea)
No   Yes   Heart Problems
No   Yes   Musculoskeletal Problems
No   Yes   Neurologic (numbness, weakness, headaches, prior stroke)
No   Yes   Psychiatric Problems (depression, anxiety)
No   Yes   Respiratory Problems (shortness of breath, wheezing)
No   Yes   Seasonal Allergies
No   Yes   Skin Problems (rashes, excessive dryness, rosacea)
No   Yes   Urinary Problems (pain or discomfort, blood in urine)

Pregnant/Nursing   Other Condition/Illness ______________

List any previous major injuries/surgeries/hospitalizations: ______________

Eye History: Do you have or have you ever had any of the following problems:

Blurred Vision   Cataracts   Double Vision   Dry Eye   Eye Injury   Eye Surgery   Flashes   Floaters   Glaucoma

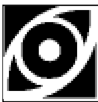
Lazy/Crossed Eye   Loss of Vision   Macular Degeneration   Migraine/Headache   Retinal Detachment

Are you interested in correcting your vision with LASIK Surgery?   Yes   No

Family History (Mother, Father, Grandparents, Siblings)

Blindness   Cataract   Glaucoma   Lazy/Crossed Eye   Macular Degeneration   Retinal Detachment

Diabetes   High Blood Pressure   Other Eye Disease or Condition: ______________



Clarkson Eyecare

PATIENT HISTORY QUESTIONNAIRE

(completion required at each patient appointment)

Marital Status: Single Married Other

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No If yes, please describe: ____________

____

Smoking History

- Current Every Day Smoker
- Current Some Day Smoker
- Former Smoker
- Never Smoker
- Smoker (Current Status Unknown)

Do you drink alcohol? Yes No ________________________________

Do you use illegal drugs? Yes No ________________________________

Have you ever been exposed to or infected with: HIV Hepatitis

If patient is 18 or under, please complete:

Any prenatal, perinatal, or postnatal problems? Yes No ________________________________

Any developmental problems? Yes No ________________________________

Do you have any concerns with your child's school performance?________________________________

Last eyecare provider:________________________________ Date of last eye exam ____________________

Are you currently having eye or vision problems? Yes No

If yes, please explain ____

Do you wear glasses? Yes No How old are they?_______ Are they bifocals? Yes No Are they for Reading Distance Both

Have you ever worn contact lenses? Yes No If yes, when were they prescribed? ________________________________

Do you wear contacts now? Yes No If not, why did you quit? ________________________________

Are you interested in wearing contact lenses? Yes No If yes, please read the following information regarding contact lenses.

Clarkson Eyecare prescribes quality contact lenses to improve your vision and your lifestyle. Contact lenses are FDA regulated medical devices that can cause discomfort, infections, and even permanent vision loss if not cared for properly. New and existing contact lens wearers require additional time and testing during an eye examination to minimize the risk of serious eye problems. This additional testing is only done for contact lens wearers, not for patients who do not wear contact lenses. For this reason, there are additional contact lens evaluation and services fees for new and existing contact lens wearers. Your contact lens evaluation and services fee includes:

1. Specific curvature measurements of the corneas
2. Evaluation of current and new lenses to ensure optimal fit, vision and comfort
3. Medical assessment of the cornea, tear film and conjunctiva as they relate to contact lens wear
4. Instructions regarding safe contact lens wear, care and proper cleaning and solutions
5. Contact lens follow up care for 90 days

If you have any questions, please do not hesitate to speak with your doctor.

Payment for all services and products is the responsibility of the patient.

I agree to pay all copays, deductibles, co-insurances and non-covered services as determined by my insurance company.

I understand there is a returned check fee applied to every returned check.

I agree to pay an additional collection fee for all accounts not paid in the time stated on the final monthly statement.

I authorize the release of medical information concerning my illness and treatment by Clarkson Eyecare to my insurance company.

I also authorize the release of my personal medical information to any doctor whom I may be referred to.

I understand verification of eligibility is not a guarantee of payment as stated by my insurance company.

I authorize payment of my insurance benefits to Clarkson Eyecare.

We will file all insurance forms if Clarkson Eyecare is a participating provider for your plan.

We will supply you with an itemized statement which you may submit to your insurance carrier.

PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE

________________________________ ____________________

Signature of patient or legal guardian Today's Date

Updated May 2011