



Today's Date _____/_____/_____

Referred By _____

Spouse _____

Name _____ Responsible Party _____

Address _____ Medical Doctor _____

_____ Specialists _____

City _____ Date/Place of Last Exam _____/_____/_____

State _____ Zip _____

Phone _____ Date of Last Medical exam _____/_____/_____

Cell Phone _____ Emergency Contact _____

Email _____ Emergency Phone _____

Date of Birth _____/_____/_____ Hobbies/Interests _____

Social Security # _____/_____/_____

Occupation _____ Preferred Language

Employer _____ English Spanish Other _____

Work Phone _____ Ethnicity (circle one)

Race (circle one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ White ☐ Black/African American ☐ Asian

☐ Native Hawaiian/Other Pacific Islander

☐ American Indian/Alaskan Native

Insurance (please bring your insurance card to your appointment)

Primary _____

Secondary _____

MEDICAL HISTORY QUESTIONNAIRE - PERSONAL MEDICAL HISTORY

Do you have any allergies to medications? ☐ No ☐ Yes (list) _____

List any medications and reason. (Include oral contraceptives, aspirin, over the counter medications and home remedies.)

List all major illnesses/health conditions. _____

List all major injuries, surgeries and/or hospitalizations you've had. _____

MEDICAL HISTORY QUESTIONNAIRE - PERSONAL MEDICAL HISTORY

Check any of the following that you have had: ☐ Lazy Eye ☐ Eye Injury ☐ Glaucoma ☐ Cataracts
☐ Retinal Disease ☐ Surgery to Your Eye(s) - please describe _____

CHECK ALL THAT APPLY

Do you smoke? ☐ No ☐ Yes Amount _____

Have you ever smoked? ☐ No ☐ Yes

Do you consume alcohol? ☐ No ☐ Yes Amount _____

Are you pregnant and/or nursing? ☐ No ☐ Yes Due Date _____

Do you wear glasses? ☐ No ☐ Yes How old are your present pair of lenses? _____ Frame? _____

Do you use a computer ☐ No ☐ Yes Hours per day? _____ Distance from computer? _____

Do you experience problems with glare? ☐ No ☐ Yes

Do you experience problems with night vision? ☐ No ☐ Yes

Do you experience visual difficulty when driving? ☐ No ☐ Yes

Do you wear prescription sunglasses? ☐ No ☐ Yes

Do you wear contact lenses? ☐ No ☐ Yes

If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐ No ☐ Yes

Type of contact that you wear: ☐ Soft ☐ Rigid ☐ Extended Wear Brand _____

Are you satisfied with your current contact lenses? ☐ No ☐ Yes

Comments _____

FAMILY HISTORY (parents, grandparents -signify maternal or paternal, siblings, children; living or deceased)

Blindness	☐ No ☐ Yes ☐ Possibly	Relationship _____
Cataract	☐ No ☐ Yes ☐ Possibly	Relationship _____
Crossed Eyes	☐ No ☐ Yes ☐ Possibly	Relationship _____
Glaucoma	☐ No ☐ Yes ☐ Possibly	Relationship _____
Macular Degeneration	☐ No ☐ Yes ☐ Possibly	Relationship _____
Retinal Detachment/Disease	☐ No ☐ Yes ☐ Possibly	Relationship _____
Arthritis	☐ No ☐ Yes ☐ Possibly	Relationship _____
Cancer	☐ No ☐ Yes ☐ Possibly	Relationship _____
Diabetes	☐ No ☐ Yes ☐ Possibly	Relationship _____
Heart Disease	☐ No ☐ Yes ☐ Possibly	Relationship _____
High Blood Pressure	☐ No ☐ Yes ☐ Possibly	Relationship _____
Kidney Disease	☐ No ☐ Yes ☐ Possibly	Relationship _____
Lupus	☐ No ☐ Yes ☐ Possibly	Relationship _____
Thyroid Disease	☐ No ☐ Yes ☐ Possibly	Relationship _____
Other _____	☐ No ☐ Yes ☐ Possibly	Relationship _____

HIPPA NOTIFICATION

I acknowledge that I have had an opportunity to review/receive a copy of the Privacy Practices at Prairieland Eye Clinic.

RESPONSIBILITY OF PAYMENT

I understand that my insurance provider may not cover some or all of the services or products I am receiving today. Although Prairieland Eye Clinic may provide the service of billing my insurance, it is not a guarantee of payment. I understand that my coverage is a contract between my insurance company and myself. I have decided to receive the services and/or materials that are being submitted to my insurance and agree to be financially responsible for any uncovered expenses. I authorize the use of this form on all of my insurance submissions and release information. I understand that I am responsible for my bill. I authorize direct payment to my doctor.

Signature _____

Date _____