A1A FAMILY EYECARE

Medical History Questionnaire

Today's Date: _____ Last Eye Exam: _____

Name: _____ Date of Birth: _____

Last First MI

Sex: ☐ M ☐ F Social Security #: _____ Cell Phone: _____

Address: _____ Home Phone: _____

_____ E-Mail: _____

City State Zip code

Last Medical Exam: _____ Primary Care Doctor: _____ Dr.'s Phone: _____

MEDICAL HISTORY

Do you have any allergies to medications? ❑ No ❑Yes If yes, explain: _____

_____

_____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

_____

_____

Are you pregnant and/or nursing? ❑No ❑Yes

Have you had any of the following:

❑ Crossed Eyes ❑ Lazy Eye ❑ Drooping Eyelid ❑ Prominent Eyes

❑Glaucoma ❑Retinal Disease ❑Cataracts ❑Eye Infections ❑Eye Injury _____

❑Other: _____

Do you wear glasses? ❑No ❑Yes If yes, how old is your present pair of glasses? _____

Do you currently wear prism glasses? ❑No ❑Yes If yes, what office prescribed them? _____

Do you wear contact lenses? ❑No ❑Yes If no, are you interested in trying contact lenses? ❑ Yes ❑ No

Type of contact lenses: ❑ Soft ❑ Hard ❑ Scleral Are they comfortable? ❑ Yes ❑ No

Contact Lens Brand: _____How old is your present pair of lenses? _____

Do you drive? ❑ No ❑ Yes If yes, do you have visual difficulty when driving? ❑ No ❑ Yes

If yes, please describe: _____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	_____
Cataract	❑	❑	❑	_____
Cross Eyes	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment	❑	❑	❑	_____
Arthritis	❑	❑	❑	_____
Cancer	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
Heart Disease	❑	❑	❑	_____
High Blood Pressure	❑	❑	❑	_____
Kidney Disease	❑	❑	❑	_____
Lupus	❑	❑	❑	_____
Thyroid Disease	❑	❑	❑	_____
Other_____	❑	❑	❑	_____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ I would prefer to discuss my Social History information directly with my doctor.

Do you use tobacco products? ❑No ❑Yes If yes, type/amount/how long: _____

Do you drink alcohol? ❑No ❑Yes If yes, type/amount/how long: _____

Do you use illegal drugs? ❑No ❑Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with:

❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision/Halos	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy or Gritty Feeling	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excess Tearing/Watering	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE			
Thyroid/Other Gland	❑	❑	❑

SYSTEM	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post-Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
VASCULAR / CARDIOVASCULAR			
Diabetes	❑	❑	❑
Heart Pain	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL			
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENITOURINARY			
Genitals/Kidney/Bladder	❑	❑	❑
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC / HEMATOLOGIC			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
ALLERGIC/IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

_____

Doctor's Signature:_____ Date:_____

A1A FAMILY EYECARE

Patient Name: _____ DOB: _____
Last First MI

Responsible party for account: _____ DOB: _____ Phone: _____

Did anyone refer you to us? _____

Insurance Information

Primary Medical Insurance: _____ ID#: _____

Primary Insured's Name: _____ DOB: _____

Employer: _____

Vision Insurance: _____ ID#: _____

Primary Insured's Name: _____ DOB: _____

Employer: _____

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

- All professional services, which includes eye examinations and office visits, must be PAID IN FULL when services are rendered.
- All materials, such as glasses and contact lenses must be PAID IN FULL before orders are placed.
- Any balance incurred as a result of not having a required referral or correct insurance information will be your responsibility.
- If your claim is denied for any reason or we have not received payment within 4-6 weeks from filing, you are responsible for the balance due within 30 days.
- We do not accept personal checks.

Patient or Guardian Signature_____ Date _____

The Florida Board of Optometry has adopted regulation 59-V3.010. that requires all patients to have dilation upon their initial examination. If you have not previously been dilated under our care, then we would be required to perform the procedure.

Dilation of the eye expands the pupil and allows a more thorough examination of the retina than would be possible without the procedure.

These are a few things you should be aware of concerning dilation:

- Dilation will enlarge your pupils, which will decrease your ability to see reading distance
- Dilation may make it difficult to see at a distance and allow sunlight to be very uncomfortable
- Driving a vehicle may be difficult after dilation
- If you elect to have the procedure, it will be an additional 30-45 minutes to do the examination, allowing sufficient time for the dilation drops to take effect
- The effect of the dilation will last 4-6 hours

OPTOMAP RETINAL EXAM

We are pleased to be able to offer our patient the Optomap Retinal Exam which allows our doctors to review an ultra-wide view of the retina (back of the eye). This evaluation can lead to the early detection of many eye diseases like glaucoma, macular degeneration and retinal detachment. This technology can also detect systemic disorders like diabetes, high blood pressure, cholesterol and even cancer. This exam is painless, quick and in MANY cases does NOT require dilating drops. Since this test is not covered yet by most insurance plans, there will be a minimal fee of $39.00 for this test.
Please note that if you are experiencing symptoms of flashes, floaters or if you are concerned with or have been diagnosed with cataracts, dilation will be necessary to evaluate these conditions further. Diabetes or other medical conditions may require dilation as well. The Optomap is still an option, but dilation may be required.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS, after reading and understanding all aspects of the dilation procedure.

___ I understand the above and elect to have my eyes dilated.

___ I understand the above and elect NOT to have my eyes dilated.

___ I understand the above and elect to have the retinal exam from Optomap.

Patient Signature _____ Date _____