

Medical History Questionnaire

Patient Last name _____ First name _____ MI _____

Date of Birth _____ SS# _____ Sex (M / F)

Address _____ City _____

State _____ Zip code _____ Home phone () - _____

Work phone () - _____ Cell phone () - _____

Email _____

Responsible Party _____ SS # _____

Occupation/Employer _____ Primary Insurance _____

Emergency contact _____ Phone # () - _____

When was your last exam? _____ Were you dilated? _____

Medical Information

Please make sure and go over any medications that you are currently taking with our technician and/or Doctor.

Do you currently have any problems in the following areas?

Loss of vision	Y / N	Cardiovascular	Y / N
Blurred vision	Y / N	Respiratory	Y / N
Fluctuating vision	Y / N	Gastrointestinal	Y / N
Redness	Y / N	Muscle/Bones/Joints	Y / N
Itching/burning	Y / N	High Blood Pressure	Y / N
Excess tearing	Y / N	Endocrine (diabetes...)	Y / N
Cross eye/lazy eye	Y / N	Skin	Y / N
Fever	Y / N	Headaches	Y / N
Sinus (ear,nose,throat)	Y / N	Mental	Y / N

Family History

High Blood Pressure	Y / N	relation _____
Diabetes	Y / N	relation _____
Glaucoma	Y / N	relation _____
Macular Degeneration	Y / N	relation _____
Retinal Detachment	Y / N	relation _____
Cataracts	Y / N	relation _____

Personal Eye Information

Do you drive? _____ Do you have difficulty driving? _____

Do you wear contact lenses? _____ Have you ever tried contacts? _____

Do you wear glasses? _____ How long have you worn glasses/contacts? _____

Do you have any eye conditions or problems? _____ If yes please list _____

Have you ever had any eye operations? _____ If yes please list with dates _____

Patient Agreement of Financial Responsibility and Consent to Treat

- Payment for annual deductibles 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 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 & Consent

Signature _____

Date _____

Optomap

The Doctors highly recommend the Optomap exam because of these benefits.

- Most patients can avoid having their pupils dilated with drops.
- It's fast, easy and comfortable.
- It enables us to educate you more fully about your eye health.
- A digital record of your retina that becomes part of your permanent file.
- It enables us to better monitor your eye health annually.
- Gives a more complete view of the back of your eye (the retina) than previously possible.

The fee for this extended exam is only \$30.

I accept - Patient signature _____ Date _____

I decline - Patient signature _____ Date _____