20(15 EyeCare℠ Focusing on the Future

MEDICAL HISTORY QUESTIONNAIRE

Date: _____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
E-mail: _____
Guardian (If Applicable): _____
Birth Date: ____/____/____ Age: _____

Occupation: _____
Employer: _____
Cell Phone: _____
Home Phone: _____
Optometric Physician: _____
Last Eye Exam: _____

Referral

How did you find us? ☐ Previous Patient ☐ Family Member _____ ☐ Work/Live Close By ☐ Website
☐ Insurance Website ☐ Friend _____ ☐ Doctor _____

Insurance *(Please check **ALL** that apply)*

Vision Plan: ☐ VSP ☐ EyeMed ☐ Humana ☐ Spectera ☐ Superior ☐ Metlife ☐ Davis Vision
☐ BCBS (Blue Vision) ☐ NVA ☐ Aetna ☐ Avesis ☐ Kaiser ☐ Other _____

Medical Plan: ☐ BCBS ☐ Humana ☐ United Healthcare ☐ Kaiser ☐ Medicare ☐ Aetna ☐ Cigna
☐ Ambetter ☐ Other _____

☐ **I give permission to 20(15 Eyecare to file my insurance. I am responsible for any uncovered or denied services.**

Chief Complaint - Reason for Eye Exam: *(Please check **ALL** that apply)* _____

☐ Ocular Wellness Exam/Annual Eye Exam: ☐ Glasses ☐ Contacts ☐ Refractive Surgery Evaluation
☐ Contact Lens Exam - *Evaluation, fitting and follow-up (The additional cost may **NOT** be covered by your Vision Plan.)*
Do you wear contacts? ☐ Yes ☐ No ☐ I want to discuss contact lens options.
Do you want ☐ Daily Disposable ☐ 2 week Disposable ☐ 1 month Disposable ☐ RGP Contacts (gas permeable)

☐ Medical Eye Exam: _____
☐ Blurred Vision at ☐ Distance ☐ Computer ☐ Near ☐ All distances
☐ Red Eye(s) ☐ Right Eye ☐ Left Eye ☐ Both Eyes ☐ Discharge ☐ Eye Drops _____
☐ Dry Eye(s) ☐ Right Eye ☐ Left Eye ☐ Both Eyes ☐ Burning ☐ Eye Drops _____
☐ Allergy Eye(s) ☐ Right Eye ☐ Left Eye ☐ Both Eyes ☐ Itching ☐ Eye Drops _____
☐ Headaches ☐ with computer use ☐ in the afternoon ☐ Upon awakening
☐ Diabetic Ocular Exam ☐ Last A1C _____ ☐ Last sugar _____ ☐ Diabetic Retinopathy

Medical History *(This is kept strictly confidential)*

What is your general health status? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No Do you use illicit drugs? ☐ Yes ☐ No
If this applies, are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No
Do you have allergies to medications? ☐ Yes ☐ No If yes, please list: _____

Please list names and doses of *ALL* medications you take:

Medication	Dosage	Condition *(Diabetes, Hypertension, etc.)*

Please list any recent injuries, surgeries and/or hospitalizations:

Date	Description *(Details if applicable)*