20(15 EyeCare™ Focusing on the Future

MEDICAL HISTORY QUESTIONNAIRE

Date: _____

Previous Patient

Name: _____ Occupation: _____

Change of address? If yes, please update below. ☐ No change Birth Date: ____/____/____ Age: _____

Address: _____ **Hobbies:** ☐ Tennis ☐ Golf ☐ Cycling ☐ Running/Walking

City: _____ State: _____ Zip: _____ ☐ Water Sports ☐ Knitting ☐ Painting ☐ Photography

☐ **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: _____

Do you have: ☐ Diabetes ☐ High Blood Pressure ☐ Autoimmune Disease ☐ Thyroid Disorders ☐ Cancer

Please list names and doses of CURRENT medications you take:

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

Consent for Dilated Eye Exam / Retinal Photography

Pupil dilation is a routine part of our comprehensive examination. This involves inserting medication eye drops into each eye, which takes about 15 minutes to take effect. Dilation makes your pupils larger, so the Optometrist can get a better look inside your eye. This is done to evaluate for ocular diseases and systemic disorders such as diabetes and hypertension. Dilation will last about 3 hours. It will make it difficult to see up close and you will be more sensitive to light. Dilation is usually not required to determine your prescription for glasses or contacts.

☐ I would like my eyes dilated today ☐ I decline dilation ☐ I wish to reschedule dilation (up to 30 days at no charge)

☐ I would like my eyes photodocumented today (up to $39 co-pay) ☐ I decline retinal photography

Patient or Guardian Signature _____

Doctor's Notes

VP	MP					
☐ P92004	☐ P99201	☐ P99211	Diabetes	Glaucoma	VAcEG 20 /	
☐ P92014	☐ P99202	☐ P99212	Hypertension	Cataracts	VAcCL 20 /	
☐ P92012	☐ P99203	☐ P99213	High Cholesterol	AMD	C / D ____ ____	
☐ P90040	☐ P99204	☐ P99214	☐ P92310	☐ P92083	☐ P92250	
☐ P90050	☐ P4074	☐ P68761	☐ P92072	☐ P92081	**F/U: 1 day 1 week 1 month** _____	