PATIENT HISTORY QUESTIONNAIRE

Thank you for choosing our office. In order to serve you properly, we need the following information. All information will be confidential.

☐ Dr. ☐ Miss Last Name _____ First Name _____ MI____

☐ Mr. ☐ Ms. Address_____ City _____ State ____ Zip_____

☐Mrs. ☐ Other ____ Home phone _____ Work phone _____ Cell phone _____

E-mail address _____ SS#_____ Birthdate _____ Gender M/F _____

Patient or parent/guardian's employer _____ Patient occupation _____

Emergency contact _____ Phone_____ Relationship to patient _____

Spouse or parent/guardian name_____ Employer _____ Phone _____

Patient: Full-Time Student? ☐ Yes ☐ No

How would you like us to contact you? _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient _____

Address_____ Home phone _____ Cell phone_____

Drivers license #_____ Birthdate _____ Employer _____ Work phone_____

Is this person a patient in our office?_____ Have we seen any other members of your family? _____ If so, whom_____

INSURANCE INFORMATION

Routine Well Vision Insurance:

Name of insured _____

Relation to patient _____ Birthdate_____

Insured SS/ID#_____ Group#_____

Insurance _____

Employer_____

Medical Insurance:

Name of insured _____

Relation to patient _____ Birthdate_____

Insured SS/ID# _____ Group #_____

Insurance _____

Employer _____

Authorization & Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the doctor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I agree to be financially responsible for all charges relative to my provider plan.

If Harvey Eye Center is not a provider for my insurance, I understand that they will assist me in receiving reimbursement as much as possible but I am responsible for my bill at the time of services.

I have read and understand this information.

X_____ Date _____

Signature of patient (or parent/guardian if minor)

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Nickname: _____ Date of Birth: ____/____/_____

Primary Care Physician: _____ Referring /Specialty Dr. _____

Pharmacy: _____ Location(street & city) _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Preferred Language: ☐ English ☐ French ☐ Italian ☐ Japanese ☐ Portuguese
☐ Russian ☐ Spanish

Allergies:

	Reaction	Severity
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular History: (Please mark all that apply) ☐ No history of eye problems

☐ Cataracts
☐ Diabetic Retinopathy
☐ Dry Eyes
☐ Glaucoma
☐ Hyperopia (Far sighted)
☐ Iritis
☐ Keratoconus
☐ Macular Degeneration
☐ Myopia (Near sighted)
☐ Optic Neuritis
☐ Retinal Detachment
☐ Amblyopia (Lazy eye)
☐ Aphakia
☐ Astigmatism

Other _____

Ocular Surgeries: (Please mark all that apply) ☐ No prior ocular surgery

R - L	R - L	R - L	R - L
☐ ☐ Foreign Body Removal	☐ ☐ Punctal Plugs	☐ ☐ Laser	☐ ☐ Cataract Surgery
☐ ☐ Blepharoplasty	☐ ☐ Retinal Laser Surgery	☐ ☐ RK	☐ ☐ LASIK
☐ ☐ Strabismus Surgery	☐ ☐ Vitrectomy	☐ ☐ Corneal Transplant	☐ ☐ PRK (eye muscle surgery)

Other _____

Current Eye Medications: (Please list)

_____ _____ _____
_____ _____ _____

Other Medical History: ☐ No history of illnesses

☐ Thyroid Disease
☐ Anemia
☐ Arthritis
☐ Arrhythmia
☐ Asthma
☐ Bleeding Disorder
☐ Cancer _____
☐ Chicken Pox
☐ Hepatitis A / B / C
☐ Heart Disease _____
☐ COPD
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Eczema
☐ Fibromyalgia
☐ Herpes Zoster / Shingles
☐ Histoplasmosis
☐ MRSA
☐ Headache
☐ High Blood Pressure
☐ High Cholesterol
☐ Herpes Simplex
☐ Kidney Disease
☐ Multiple Sclerosis
☐ Liver Disease
☐ Meningitis
☐ Toxoplasmosis
☐ Lung Disease
☐ Lupus
☐ Migraine
☐ Psychiatric Disorder
☐ Myasthenia Gravis
☐ Sarcoidosis
☐ Stroke
☐ Sjogren's Syndrome
☐ Syphillis
☐ Temporal Arteritis

Other _____

Have you ever been diagnosed with HIV / AIDS or Hepatitis A / B / C : ☐ Yes (circle which one) ☐ No

General Surgeries / Operations: (Please check / list)

☐ Heart Bypass ☐ Pacemaker ☐ Gastric Bypass ☐ Sinus

_____ _____ _____
_____ _____ _____

Please continue on the back side of this page →

All Other Medications: (Please check / list)

□ Plaquenil □ Prednisone □ Diamox □ Topamax □ Asprin

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History:

□ Arthritis
□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Kidney Disease
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ TB

Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?_____

Drug Use: □ Yes □ No If yes what and how often?_____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

MEDICATION LIST

Patient Name: _____ DOB: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

Name and number of your pharmacy _____

_____

HARVEY EYE CENTER
2148 N. MALL DR.
ALEXANDRIA, LA 71303
318-442-0242
318-442-2406 (FAX)
DR. TONI C. HARVEY, O.D.

PRIVACY NOTICE

Harvey Eye Center requires your consent to collect personal information about you. Please read this consent form carefully and sign where indicated below.

This Medical Practice collects such information for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history to allow us to properly assess, diagnose, treat and advise on all your health care needs.

I give my permission for my personal health information to be used for administrative purposes to assist in the running of Harvey Eye Center, including disclosure to others involved in my healthcare, such as treating doctors and specialists within and outside this Medical Practice. This may occur through referral to other Doctors, or for medical tests and in the reports or results returned to my doctor following referrals.

I understand by signing below that the Practice is authorised on my behalf to use my relevant personal health information and I am free to withdraw my consent at any one time by verbal or written notification.

Print name of Patient: _____ Date: _____

Signature of Patient: _____

Print name and signature of Parent /Guardian (if under 18): _____

Financial Agreement

I agree that in return for services provided to the patient by Harvey Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Harvey Eye Center for payment. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Harvey Eye Center. If copayments and/or deductibles are designated by my insurance company and/or health plan, I agree to pay them to Harvey Eye Center. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____

Signature of Patient (Parent, if Minor) Date