Patient History Questionnaire

Today's Date _____

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Home Phone _____
Date of Birth _____ Occupation _____ Employer _____
Emergency Contact Name _____ Phone Number _____
Date of Last Eye Exam _____ Dilated? Yes/No Referred By _____
Primary Vision Coverage _____ Secondary Coverage _____

Medical Information

email:

How is your general health? _____
Do you take medications for any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____
Diabetes Yes/No _____ Type _____ Date of diagnosis _____
Allergies to medication Yes/No Which? _____ Reactions? _____
Other health problems _____
Current medication(s) _____
Have you had any operations? Yes/No Kind? _____ When? _____
Name of family doctor and/or primary care physician _____
Date of last visit _____ Date your blood pressure was last checked _____

Family History

High blood pressure	Yes/No	Relation	_____	Macular degeneration	Yes/No	Relation	_____
Diabetes	Yes/No	Relation	_____	Retinal detachment	Yes/No	Relation	_____
Glaucoma	Yes/No	Relation	_____	Cataracts	Yes/No	Relation	_____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? _____
Have you had any eye operations? Yes/No Type _____ Date _____
Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type	_____

Additional information _____

Doctor Use Only

Reviewed by _____ ○ No changes Date _____
Reviewed by _____ ○ No changes Date _____
Reviewed by _____ ○ No changes Date _____

CASEY VISION CARE

Acknowledgement of Receipt of Privacy Policy

I understand that Casey Vision Care Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment including referrals, payment of my bills, or in the performance of the health care operations of Casey Vision Care. Our Notice of Privacy Practices explains our use and disclosure of your Protected Health Information. This notice is posted in the office reception area. I acknowledge that I can receive a copy of this notice upon request.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Guilderland Vision Care has acted in reliance upon this authorization. My written revocation must be submitted to the Practice Manager.

Disclosures

Do we have permission to:

Leave Appointment Information:		**Leave Medical Information:**	
On Phone?	[ ]	On Phone?	[ ]
Via Email?	[ ]	Via Email?	[ ]
On Office Voicemail?	[ ]	On Office Voicemail?	[ ]
Via Mail?	[ ]	Via Mail?	[ ]
With Another Person?	[ ]	With Another Person?	[ ]

Person(s) Authorized to Communicate with Casey Vision Care:

_____

Please understand that we will not be able to release any information about your medical condition to anyone not authorized by you. It is your responsibility to change and/or update this information as necessary.

Printed name (self or legal guardian): _____

Signature_____ Date:_____

PATIENT FINANCIAL RESPONSIBILITY POLICY

I understand that Casey Vision Care will be billing my insurance company. I also understand that it is my responsibility to read and understand my insurance coverage. If, for any reason, my insurance company does not pay Casey Vision Care for services provided, I agree to pay Casey Vision Care in full for all services rendered.

Signature:_____ Date:_____

DILATION?: I would like to be dilated today and understand that driving may be difficult due to sensitivity to light and some blur particularly up close for 4 to 6 hours after instillation of drops. I also understand that dilation is part of a comprehensive eye exam that allows the doctor to have the best view of my retina in order to identify issues that may impact vision and systemic health. ____**YES** ____**NO**

Signature and Date: _____