Medical History Questionnaire

Name: _____ Today's Date: _____

Address: _____ Phone: _____

_____ Work Phone: _____

Guardian (If Applicable): _____ Occupation: _____

Email: _____ Preferred Language: _____

Birth Date: _____ Social Security #: _____ Race/Ethnicity: _____

Gender: _____ Date of Last Eye Exam: _____ Date of Last Medical Exam: _____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Medical History

Do you have any allergies to medications? ❒ no ❒ yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Check any of the following that you have had: ❒ crossed eyes ❒ lazy eye ❒ drooping eyelid ❒ prominent eyes

❒ Glaucoma ❒ retinal disease ❒ cataracts ❒ eye infections ❒ eye injury

Are you pregnant or nursing? ❒ no ❒ yes

Do you wear glasses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ yes ❒ no

Family History: note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions.

Disease/Condition	No	Yes	?	Relationship To You
Blindness	❒	❒	❒	
Cataract	❒	❒	❒	
Crossed Eyes	❒	❒	❒	
Glaucoma	❒	❒	❒	
Macular Degeneration	❒	❒	❒	
Retinal Detachment or Disease	❒	❒	❒	
Arthritis	❒	❒	❒	

Disease/Condition	No	Yes	?	Relationship To You
Cancer	❒	❒	❒	
Diabetes	❒	❒	❒	
Heart Disease	❒	❒	❒	
High Blood Pressure	❒	❒	❒	
Kidney Disease	❒	❒	❒	
Lupus	❒	❒	❒	
Thyroid Disease	❒	❒	❒	
Other: _____				

✳ ***Please Turn This Form Over & Complete Side Two*** ✳

Social History: *This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.*

❒ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❒ no ❒ yes If yes, do you have visual difficulty when driving? ❒ no ❒ yes If yes, please describe:

_____

Do you use tobacco products? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you drink alcohol? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you use illegal drugs? ❒ no ❒ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

Review of Systems: Do you currently, or have you ever had any problems in the following areas?

System	NO	YES	?
Constitutional			
Fever, Weight Loss/Gain	❒	❒	❒
Integumentary (Skin)	❒	❒	❒
Neurological			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
Eyes			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection, Eye or Lid	❒	❒	❒
Sties or Chalazion	❒	❒	❒
Flashes/Floaters in Vision	❒	❒	❒
Tired Eyes	❒	❒	❒
Endocrine			
Thyroid/Other Glands	❒	❒	❒

System	NO	YES	?
Ears, Nose, Mouth, Throat			
Allergies/Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
Respiratory			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
Vascular / Cardiovascular			
Diabetes	❒	❒	❒
Heart Pain	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
Gastrointestinal			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
Genitourinary			
Genitals/Kidney/Bladder	❒	❒	❒
Bones / Joints / Muscles			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
Lymphatic / Hematologic			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
Allergic / Immunologic	❒	❒	❒
Psychiatric	❒	❒	❒

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

_____

_____ _____

Doctor's Signature Date

RIVERDELL FAMILY VISION CARE
297 KINDERKAMACK ROAD
ORADELL, NEW JERSEY 07649
201-265-7900

Medical Release/Lifetime Signature

I authorize payment for all insurance benefits for services rendered in this office be made payable to Riverdell Family Vision Care. I authorize this office to release any information necessary to determine the benefits payable for related services with the understanding that approval by my insurance carrier does not guarantee payment. I permit a copy of this authorization to be used in place of the original. This form will serve as a lifetime signature form.

I understand that I am responsible for all charges not covered by my insurance carrier. Medicare and some other insurance companies do not pay for the refractive portion of the examination. If refraction (the portion of the exam that determines if you need eyeglasses) is necessary, Medicare and other insurance carriers will disallow it, stating that it is not a covered insurance benefit. Therefore, the patient will be responsible for the refraction charge, as well as any other "non-covered" services under Medicare or any other private insurance plan. In most cases, contact lens fees (fitting time and materials) are not covered through insurance and are payable at the time services are rendered. I understand that I will be responsible for co-payments and deductibles and for services not covered by your insurance plan, including Medicare.

I hereby give my consent for me or my child to be seen. I understand that my eyes may be dilated during the examination.

Signature_____

Date_____

HELP US LEARN HOW YOU USE YOUR EYES

IN ORDER TO FULLFILL ALL OF YOUR EYEWEAR NEEDS, PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT HOW YOU USE YOUR EYES.

1. Do you work on a computer? YES_____ NO_____
2. How many hours per day? _____
3. Do you participate in sports? YES_____ NO_____
   Which sports? _____

   Are glasses a problem in any of these sports? YES_____ NO_____
4. List any special hobbies that are visually demanding:

   _____

   _____
5. Are you extremely bothered by glare? YES_____ NO_____
6. If you do not wear contact lenses, would you be interested in one day lenses to be worn occasionally (also available in bifocal and astigmatism) YES_____ NO_____

DIGITAL RETINAL IMAGERY

Riverdell Family Vision Care is pleased to announce that we have acquired a state-of-the-art digital retinal imaging system. This sophisticated camera records images of the back of your eye which can be viewed by you and your doctor during your examination. Digital retinal imagery assists our doctors in diagnosing serious eye disease such as Glaucoma and Macular Degeneration as well as systemic eye diseases such as Diabetes and Hypertension by direct visualization of the blood vessels and nerve tissue of your eyes. Images are permanently stored in our computer for future reference and can be printed or emailed to other practices. We strongly encourage all patients to have this test performed. The cost for baseline imaging is $15.00 per eye and is not reimbursed by your insurance.

I wish to have this test YES_____

I do not wish to have this test NO_____

_____

Signature

INSURANCE INFORMATION

PRE-AUTHORIZATION SHEET

DATE:_____

Patient's Name:_____ Date of Birth:_____

Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

Insured's Name: _____ Date of Birth: _____

SS# _____

PRIMARY INSURANCE :_____

In-Network _____ Out of Network _____ Referral Required Yes____/No____

Deductibles? _____ Has it been met? Yes ____/No ____ Copay: _____

VISION CARRIER: _____Referral Required Yes ___/No____

Copay? _____

SECONDARY INSURANCE: _____

Dr. Meyer accepts assignment from my insurance company, however, I realize all fees are ultimately my responsibility. Should my insurance company fail to pay this claim within 45 days from the date the initial claim is filed, I agree to aid with the collection of this fee from my insurance company. Should my insurance company reject this claim, I agree to pay the bill upon receipt.

Patient (Guarantor) Signature _____ **Date** _____

We are now making greater use of e-mail to communicate with our patients. To help us provide the most prompt service possible, please enter your current e-mail address below.

E-Mail Address _____