ADAMS EYE CARE CLINIC

103 N ST JOSEPH ST. MORRILTON, AR 72110
(501)354-1610

Office Use Only-ID#:_____

MEDICAL HISTORY QUESTIONAIRE

April2012

Date_____ Home Phone_____ Work Phone_____ Cell Phone_____
Patient's Name_____ Social Security #_____ Last Eye Exam_____
Patient Employer_____ Occupation_____ Last Eye Dr._____
Spouse or Parent's Name_____ Your Sex ___M ___F Last Medical Exam_____
Address_____ Birthdate_____ Age___ Current Medical Dr._____
Insurance_____ Name of Cardholder _____DOB_____SSN_____

Medical History

Allergies to Medication_____ Medicine Taking_____

List Surgeries or Hospitalization_____

Circle any of the following that you have had: crossed eyes, lazy eye, glaucoma, retinal disease, cataracts, or eye injury.

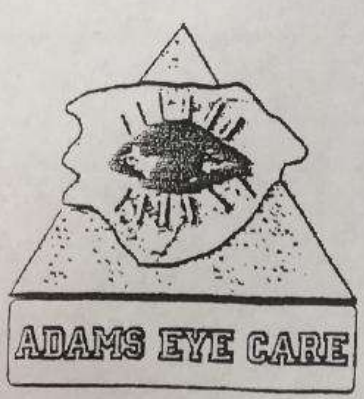
Are you pregnant or nursing? ____ Yes _____ No

Do you wear glasses or contact lenses? _____ Glasses _____ Contacts _____ Neither

Social History

Marital Status (Circle One)
Single Married Widowed Divorced

Do You Drive? ___Y___N
Do you use tobacco? ___Y___N
Type/how often? _____
Do you drink alcohol? ___Y___N
Type/how often? _____
Exposed to or Infected with:
Gonorrhea ___Y___N
Hepatitis ___Y___N
HIV ___Y___N
Syphilis ___Y___N



Review of Systems-Do you currently,

	Yes	No
Fever		
Weight Loss/Gain		
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		
Itching		
Burning		
Foreign Body Sensation		
Excess Watering		
Light Sensitivity		
Eye Pain/Soreness		
Chronic Infection		
Sties or Chalazion		
Flashes or Floaters		
Tired Eyes		
Endocrine		
Thyroid		

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

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	Yes	No	Relationship to you
Blindness			
Cataract			
Crossed Eyes			
Glaucoma			
Macular Degeneration			
Retinal Detachment Disease			
Systematic Disease/Conditions			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			

Insurance Information (See copy of insurance card/make copy of card)

INSURANCE AUTHORIZATION

I, the undersigned, have insurance coverage as noted and assigned directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid to insurance. I hereby authorize Adams Eye Care Clinic, P.A. to release information necessary to secure payment to benefits. I authorize the use of this signature on all my insurance submissions.

I understand that if my insurance carrier is not contracted with Adams Eye Care Clinic, P.A. that the incurred charges will be my responsibility. I understand that I am responsible for any deductibles, co-pays, or any portion that the insurance company has allowed but not paid for. Also, it may be my responsibility to obtain a referral in order for payment to be made for treatment by an Adams Eye Care physician.

_____ _____

(Signature of Insured/Guardian) (Date)

Emergency notification_____Relationship_____Phone number_____

Acknowledgement

By my signing below, I acknowledge that I have received a copy of the Adams Eye Care Clinic, P.A. Notice of Privacy Policies

_____ _____

(Signature of Patient/Guardian) (Date)