Medical History Questionnaire

Name:_____ Sex☐M ☐F Birth Date: ___/___/_____ Today's Date ___/___/_____

Address:_____ Phone (H): _____ (C) _____

City/State/Zip: _____ Email _____

Insurance Information (We will be making a copy of your insurance card)

Employer _____Occupation: _____ Insurance Company _____

Policy Holder: _____ Insured ID: _____Birth Date ___/___/____ Relationship to patient: _____

Medical History Last Eye Exam: ___/___/_____

List of medications that you are allergic to: _____

List any medications you are taking: _____

List surgeries and /or hospitalizations you have had within last 6 months:_____

Women: Are you pregnant and/or nursing? ☐yes ☐no Do you wear glasses? ☐yes ☐no or contact lenses? ☐yes ☐no

Family History (Blindness, cataract, glaucoma, cancer, diabetes, heart disease, high blood pressure, kidney and liver disease)

_____

_____

Social History

	Yes	No		Yes	No
Do you have visual difficulty driving w/ current glasses/contacts?	☐	☐	Do you use controlled substance?	☐	☐
Do you drink alcohol?	☐	☐	Do you use tobacco products?	☐	☐

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ None

Review of Systems

	Yes	No		Yes	No		Yes	No
High Cholesterol	☐	☐	Psychiatric problems	☐	☐	Floaters	☐	☐
Drastic weight loss	☐	☐	High blood pressure	☐	☐	Flashes of Light	☐	☐
Skin Disease	☐	☐	Heart disease	☐	☐	Vision Loss	☐	☐
Headaches/Migraines	☐	☐	Diarrhea/Constipation	☐	☐	Blurred Vision	☐	☐
Thyroid Gland Problems	☐	☐	Kidney disease	☐	☐	Dryness of eyes	☐	☐
Allergies/Hay Fever	☐	☐	Rheumatoid Arthritis	☐	☐	Eye Itching	☐	☐
Chronic Cough	☐	☐	Muscle/Joint Pain	☐	☐	Eye Pain	☐	☐
Dry Mouth/Throat	☐	☐	Anemia	☐	☐	Cataract	☐	☐
Diabetes	☐	☐	Bleeding problems	☐	☐	Glaucoma	☐	☐
Use of Insulin	☐	☐	Immunologic disease	☐	☐	Double Vision	☐	☐

Comments: _____

HIPAA Notice and Consent

I have reviewed and understand the HIPAA privacy policy that is shown to me. I give this clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

Patient's/Guardian's Signature _____ Date____/____/_____

Informed Refusal for Pupil Dilation

I have refused or will reschedule my dilation. I understand the doctors of Clearvision Eyecare Ltd recommend it to more thoroughly evaluate the internal health of my eyes. Without dilation, serious eye diseases, such as diabetes, retinal detachment or malignant tumor (which can result in blindness, loss of an eye, or even death) could be present and not seen by the doctor. I understand there is no alternative procedure that can replace dilation of my pupils. I agree to indemnify, hold harmless and waive and release from any and all claims, legal actions and attorney fees, which may arise as a result of my failure to comply with the instructions or recomendations of my optometrist, Clearvision Eyecare Ltd and their technicians.

Patient's/Guardian's Signature _____ Date____/____/_____

Doctor's Signature: _____ Date: _____/_____/_____