

# Premier Eyecare of Edmond Medical History Questionnaire

DATE	INT.

## PATIENT INFORMATION

Name: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_  
 Address: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Preferred method of contact: (circle) Call Text Email

## INSURANCE INFORMATION

Primary Member's Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_  
 Social Security: \_\_\_-\_\_\_-\_\_\_\_\_  
 Primary Medical Doctor: \_\_\_\_\_ City: \_\_\_\_\_

## MEDICAL HISTORY

### Personal/Family History

Please indicate if the patient or any family members have a history of any of the following:

CONDITION	PATIENT	FAMILY	UNSURE		PATIENT	FAMILY	UNSURE
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Health Conditions \_\_\_\_\_

Allergic to medications? (circle) Yes No If yes, explain: \_\_\_\_\_

List any medications currently taking: \_\_\_\_\_

## ANSWER IF UNDER 18:

Has the child been exposed to Tobacco products, Alcohol or Recreational drugs? (circle) Yes No  
 If yes explain \_\_\_\_\_

Was the child born premature? (circle) Yes No      Has the child ever had a seizure? (circle) Yes No

Is the patient being treated for ADD or ADHD? (circle) Yes No If yes, medication? \_\_\_\_\_

## EYEWEAR HISTORY

Has the patient ever had an eye exam? (circle) Yes No      Date of Last Exam: \_\_\_/\_\_\_/\_\_\_

Name of Eye Doctor \_\_\_\_\_ City: \_\_\_\_\_

Were glasses or contacts prescribed at this time? (circle) Yes No

If yes, when is correction worn? All the time      Reading/Near work      Distance/Driving

Is the patient planning on getting new glasses today? Yes No Unsure

Has the patient ever worn contact lenses? Yes No

Is the patient interested in contact lenses today? Yes No Unsure

Does the patient work on a computer more than 4 hours per day? Yes No

**CONTINUED ON BACK →**

**How did you become aware of our practice?**

**Friend recommendation**

**Insurance provider**

**Drove by**

**Referred by other professional**

**Other:** \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AUTHORIZATION**

I understand that I am responsible for the balance on my account for any professional services rendered by Premier Eyecare of Edmond, regardless of my insurance status.

I request that payment of authorized medical or routine vision benefits be made to Premier Eyecare of Edmond on my behalf for any services I receive. I authorize Premier Eyecare of Edmond, LLC to release to my insurance company all information necessary to determine benefits or benefits payable to related services.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

(Available at the front desk)

**I acknowledge that I have read or have had the opportunity to read Premier Eyecare's Notice of Privacy Practices.**

**Patient Name** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_