

TOLLAND EYE CARE LLC
23 C Fieldstone Commons
Tolland, CT 06084

Patient Information and Medical History Questionnaire

Name: _____ Male Female Today's Date: _____

Address: _____ Phone: _____

City: _____ Work Phone: _____ Occupation: _____

Guardian (if applicable): _____ Email Address: _____

Birth Date: ____ / ____ / ____ Social Security# ____ / ____ / ____ Last Eye Exam: _____

Medical Health Insurance: _____ Policy/ID# _____

Vision Insurance: _____ Policy/ID# _____

Medical History:

Name of Medical Doctor: _____ Dr's Phone: _____ Last Medical Exam: _____

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

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

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

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, Cataracts, eye infections or eye injury. Explain/Details: _____

Are you pregnant and/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 contacts lenses: rigid soft extended wear other Are they comfortable? yes no

Family History

Please note the following history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	YES	Relationship to you	Disease/Condition	YES	Relationship to you
Blindness	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	_____
Retinal Detach Disease	<input type="checkbox"/>	_____	Lupus	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	_____

Other _____ Yes _____

Please turn this form over and complete side two

Social History *This information is kept strictly confidential. However, 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

Have you been diagnosed with sleep apnea? no yes

Have you ever felt faint or actually fainted during any type of professional services provided to you? no yes

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

	<u>YES</u>		<u>Yes</u>		<u>Yes</u>
Constitutional		Eyes		Endocrine	
Fever, weight loss/ gain	<input type="checkbox"/>	Tired Eyes/eye strain	<input type="checkbox"/>	Thyroid/Other Glands	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	Lymphatic/Hematologic	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	Distorted Vision/Halos	<input type="checkbox"/>	Anemia	
Seizures	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	Integumentary (skin)	<input type="checkbox"/>
Stroke	<input type="checkbox"/>				
Bleeding Problems	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	Allergic/Immunologic	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	Dryness	<input type="checkbox"/>		
Tingling	<input type="checkbox"/>	Mucous Discharge	<input type="checkbox"/>	Gastrointestinal	
Paralysis	<input type="checkbox"/>	Redness	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	Sandy or Gritty	<input type="checkbox"/>	Constipation	<input type="checkbox"/>
Ears, Nose, Mouth, Throat		Itching	<input type="checkbox"/>	Genitourinary	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Burning	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	Foreign Body Sensation	<input type="checkbox"/>	Bones/Joints/Muscles	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	Glare/Light Sensitivity	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	Eye Pain or Soreness	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>
Dry throat/mouth	<input type="checkbox"/>	Chronic Infection of			
Respiratory		eye or lid	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>	Flashes/Floaters in Vision	<input type="checkbox"/>	Vascular/Cardiovascular	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	Decreased vision in		Diabetes	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	dim light	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
				Vascular Disease	<input type="checkbox"/>
				Low Blood Pressure	<input type="checkbox"/>

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

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Tolland Eye Care LLC for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid services and its agents and information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the SMC-1500 claim form or electronically submitted claim, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. **I understand that all benefits quoted to me are not a guarantee of payment by my insurance company & that final determination can only be made when the claim is processed.**