Advanced Eyecare Associates of Eastern Iowa

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Medical/Ocular Health Questionnaire

All information is kept strictly confidential. Please fill out ALL sections as completely as possible.

Patient Information

Today's Date: ____/____/_____

Name:_____

Address:_____

_____

City State Zip

Sex: M F **Birthdate:**_____

Social Security Number:_____

Home Phone Number:_____

Work/Cell Phone Number:_____

Email Address:_____

Occupation:_____

Employer:_____

Employer Address:_____

Employer Phone:_____

In Case of Emergency, Contact

Name:_____Relationship:_____

Phone Home: _____Work:_____

Insurance and Financial Information

Who is responsible for the account?_____

Relationship to Patient_____

Address_____

City State Zip

Insurance Coverage:_____

Insurance Policy Number:_____

Name on Policy:_____

Additional Insurance:_____

Policy number:_____

Name on Policy:_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have the above listed insurance coverage and assign Advanced Eyecare Associates of Eastern Iowa all insurance benefits, if any, payable to me for the services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance. If the insurance plan above does pay for services rendered, I will be refunded the covered portion of the exam service fees.** I hereby authorize the doctor to release all information necessary to secure payment of insurance benefits. I authorize the use of this signature for insurance submissions.

_____Date:_____

Medicare/Medicaid Authorization

I hereby authorize the payment of Medicare benefits be made to Advanced Eyecare Associates of Eastern Iowa on behalf of services rendered. **My signature requests payments be made and the release of necessary medical information to the Division of Medicare and Medicaid Services to pay the claim.**

_____Date:_____

MEDICAL HISTORY QUESTIONAIRE

MEDICATIONS

Please list all medications taken, including over the counter, oral contraceptives, aspirin, and home remedies

_____

_____

_____

ALLERGIES:_____

Describe ALL serious illnesses, injuries, hospitalizations, and surgeries (including eye):

_____

Primary Care Physician Information

Name:_____

Address:_____

Phone:_____ **Date of last exam:**___/____

Previous Eye Care Information

Last Eye Exam:_____/_____/_____

By: _____

Family History

Please note any family members with the following:
M = mother F = Father S = Sibling GP= Grandparent

	Yes	No		Yes	No
Arthritis ___	☐	☐	**Diabetes ___**	☐	☐
Blindness ___	☐	☐	**Glaucoma ___**	☐	☐
Cancer ___	☐	☐	**Heart Disease ___**	☐	☐
Cataracts ___	☐	☐	**Hypertension ___**	☐	☐
Cross Eyes__	☐	☐	**Macular Degen___**	☐	☐

Other_____

Social History

Do you use/have used the following:

	Yes	No	Quantity
Alcohol:	☐	☐	_____
Drugs:	☐	☐	_____
Tobacco:	☐	☐	_____

Hobbies:_____

Do you wear: **Glasses Y / N** **Contacts Y / N** **Had refractive surgery (LASIK,PRK, etc) Y / N**
Rigid / Soft / Extended wear

Do you drive: Y / N If yes, do you have visual problems when driving: Y / N Explain:_____

Please check if you currently have or have had any of the following conditions below:

Eyes/Vision:	**Yes**	**No**	**Not Sure**
Blurred Vision	☐	☐	☐
Burning Sensation	☐	☐	☐
Cataracts	☐	☐	☐
Crossed Eyes	☐	☐	☐
Distorted Vision (halos)	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Excess Tearing/ watering	☐	☐	☐
Eye pain/ soreness	☐	☐	☐
Flashes/ Floaters seen	☐	☐	☐
Gritty/ Sandy feeling	☐	☐	☐
Glare/ light sensitive	☐	☐	☐
Glaucoma	☐	☐	☐
Infection of Eye or Lid	☐	☐	☐
Itching	☐	☐	☐
Lazy Eye/ Strabismus	☐	☐	☐
Loss of Vision	☐	☐	☐
Mucous Discharge	☐	☐	☐
Macular Degeneration	☐	☐	☐
Redness	☐	☐	☐
Retinal Disease	☐	☐	☐
Styes/Chalazion	☐	☐	☐
Surgery (eye surgery)	☐	☐	☐

Bone/Joint/Muscle			
Arthritis	☐	☐	☐
Joint/Muscle Pain	☐	☐	☐
Polio	☐	☐	☐
Cancer	☐	☐	☐
Constitutional			
Fever	☐	☐	☐
Weight Loss/ Gain (rapid)	☐	☐	☐
Endocrine			
Thyroid Abnormalities	☐	☐	☐
Vascular			
Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Heart Disease	☐	☐	☐

Ear/Nose/Throat	**Yes**	**No**	**Not Sure**
Allergies	☐	☐	☐
Chronic Cough	☐	☐	☐
Runny Nose	☐	☐	☐
Sinus Infection	☐	☐	☐
Gastrointestional (Stomach)			
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Ulcers	☐	☐	☐
Genitourinary			
Chlamydia	☐	☐	☐
Gonorrhea	☐	☐	☐
Syphillis	☐	☐	☐
Kidney Disease	☐	☐	☐
Lymph/Blood			
AIDS/HIV	☐	☐	☐
Anemia	☐	☐	☐
Bleeding Disorder	☐	☐	☐
Hepatitis	☐	☐	☐
Herpes	☐	☐	☐
Neurological			
Epilepsy	☐	☐	☐
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Seizures	☐	☐	☐
Stroke	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Bronchitis/ Emphysema	☐	☐	☐
Pneumonia	☐	☐	☐
Tuberculosis	☐	☐	☐
Females: Pregnant Or Nursing	☐	☐	

For Office Use:_____
_____
_____