MEDICAL HEALTH HISTORY QUESTIONNAIRE

Grandville Eye Care 3100 Wilson Ave SW, Suite 2 Grandville, MI 49418 (616) 534-4350 www.GrandvilleEyeCare.com

GRANDVILLE Eye Care, PC

Name: _____ Today's Date: ____–____–____

Address: _____ Phone: _____

Email: _____ *We respect your privacy. Your email will never be sold or given to anyone. Work Phone: _____

Birth Date: ____–____–____ Social Security #: ____–____–____ Last Eye Exam: ____–____–____

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

Last Medical Exam: ____–____–____

MEDICAL HISTORY

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

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

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

List 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: _____

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? _____

Types of contact lenses: ○ Rigid ○ Soft ○ Extended Wear ○ Other Are they comfortable? ○ yes ○ no

FAMILY HISTORY

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	○	○	○	
Cataract	○	○	○	
Crossed Eyes	○	○	○	
Glaucoma	○	○	○	
Macular Degeneration	○	○	○	
Retinal Detachment/Disease	○	○	○	
Arthritis	○	○	○	
Cancer	○	○	○	
Diabetes	○	○	○	
Heart Disease	○	○	○	
High Blood Pressure	○	○	○	
Kidney Disease	○	○	○	
Lupus	○	○	○	
Thyroid Disease	○	○	○	
Other _____	○	○	○	

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.

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

REVIEW OF SYSTEMS

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

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	◯	◯	◯
INTEGUMENTARY(Skin)	◯	◯	◯
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 Feeling	◯	◯	◯
Itching	◯	◯	◯
Burning	◯	◯	◯
Foreign Body Sensation	◯	◯	◯
Excess Tearing/Watering	◯	◯	◯
Glare/Light Sensitivity	◯	◯	◯
Eye Pain or Soreness	◯	◯	◯
Chronic Infection of Eye or Lid	◯	◯	◯
Sties or Chalazion	◯	◯	◯
Flashes/Floaters in Vision	◯	◯	◯
Tired Eyes	◯	◯	◯
ENDOCRINE			
Thyroid/Other Glands	◯	◯	◯

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	◯	◯	◯
Sinus Congestion	◯	◯	◯
Runny Nose	◯	◯	◯
Post Nasal Drip	◯	◯	◯
Chronic Cough	◯	◯	◯
Dry Throat/Mouth	◯	◯	◯
RESPIRATORY			
Asthma	◯	◯	◯
Chronic Bronchitis	◯	◯	◯
Emphysema	◯	◯	◯
VASCULAR/CARDIOVASCULAR			
Diabetes	◯	◯	◯
Heart Pain	◯	◯	◯
High Blood Pressure	◯	◯	◯
Vascular Disease	◯	◯	◯
GASTROINTESTINAL			
Diarrhea	◯	◯	◯
Constipation	◯	◯	◯
GENITOURINARY			
Genitals/Kidney/Bladder	◯	◯	◯
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	◯	◯	◯
Muscle Pain	◯	◯	◯
Joint Pain	◯	◯	◯
LYMPHATIC/HEMATOLOGIC			
Anemia	◯	◯	◯
Bleeding Problems	◯	◯	◯
ALLERGIC/IMMUNOLOGIC	◯	◯	◯
PSYCHIATRIC	◯	◯	◯

If you answer **YES** to any of the above or have a condition not listed, please explain & list medications: _____

_____

_____

_____

_____

_____ Doctor's Signature _____ Date _____

GRANDVILLE EYE CARE

PERSONAL INFORMATION

Name _____ Birth date _____
Home Phone _____ Work Phone _____
Minor_____ Single_____ Married_____ Divorced_____ Widowed_____
Employer_____ Occupation_____
Social Security # _____-_____-_____ Referred by _____

RESPONSIBLE PARTY

Who is responsible for the account? (after insurance)
Name_____ Relationship to Patient_____
Birth date_____/_____/_____ Soc. Sec. # _____-_____-_____
Address _____
City _____ State_____ Zip _____

In the event of an emergency who should we contact?
Name _____ Relationship to Patient _____
Home Phone _____ Work Phone _____

FINANCIAL ARRANGEMENTS

For your convenience, we accept cash, check, master card or visa.
Payment in full is expected at each appointment.

INSURANCE INFORMATION

Do you have vision insurance Yes_____ No_____
If yes, we will need a copy of the insurance card.

AUTHORIZATION and RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment of examination rendered to me or my child during the period of such care to third party payers and / or health practitioners.
I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents

_____
Signature of patient or parent if minor Date

* * *Please turn over to sign HIPAA form* * *

Thank you very much for taking the time to review how we are carefully using your health information. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance officer in person or by phone.

The signature below is only acknowledgment that you have received this Notice of our Privacy Practices

Patient Name _____

Signature _____ Date _____