Midland Eye Care Medical History Form

Name (Legal/Full) _____ **Sex:** M / F **DOB** _____/_____/_____
First Last Preferred Name

Address_____ **(ZIP)**_____ **SSN #**_____/_____/_____
(18 & over only)

Phone # (____)_____ **Cell #** (____)_____**Work #** (____)_____**Occupation**_____

Guardian(s)_____ **List all family members that are patients here**_____

Referred By _____**Email**:_____ **Opt In** ◯ **Out** ◯ **for email reminders**

Insurance

Policy Holder's Name _____**DOB**_____/_____/_____ **SSN #** (needed for insurance purposes only) _____/_____/_____

Vision Insurance _____ **Medical Insurance** _____

Policy/Member ID/# _____ **Policy/Member ID/#** _____

Medical History

Date of Last Medical Exam:_____ **Name of Medical Doctor**_____**Dr.'s Phone**(___)_____

What is your general health? Excellent _____ Good _____ Fair _____ Poor_____ **Are you pregnant?** Yes____ No____ **Are you nursing?** Yes____ No____

List all Medications _____

Do you have allergies to any medications? Yes____ No____ **If yes, explain**: _____

Do you have general allergies? Yes____ No____ **Allergic to what?** _____ **What Happens?** _____

Ocular History

Date of Last Eye Exam: _____ **Do you wear eyeglasses?** Yes____ No ____ **If yes Please circle one**- Single vision, Bi-Focal or Progressive's?

Do you wear contact lenses? Yes____ No ____ **If yes, what kind?**_____ **Type of solutions/care system**:_____

Current eye drops_____ **List all current or past eyes diseases, eye injuries or eye surgeries**_____

Chief Complaint

How may we help you today? In this space please check/explain any signs and /or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eye, etc.

◯ **Annual Eye Exam** ◯ **Double vision** ◯ **Eye pain/soreness** ◯ **Watery Eyes** ◯ **Flashes of light** ◯ **Mucous Discharge**
◯ **Blurred vision** ◯ **Crossed eyes** ◯ **Glare/Light sensitivity** ◯ **Dry eyes** ◯ **Floaters** ◯ **Styes / Chalazion**
◯ **Loss of vision** ◯ **Red eyes** ◯ **Sandy/gritty feeling** ◯ **Tired eyes** ◯ **Burning/itching** ◯ **Other (Explain) _____**

Social History

This information is a protected part of your medical record and is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you use tobacco products? Yes / No If yes, type/amount/how long? _____
Do you drink alcohol? Yes / No If yes, type/amount/how long? _____
Do you use illegal drugs? Yes / No If yes, type/amount/how long? _____
Please note if you have ever been exposed to or infected with: HIV ___ Hepatitis _____ Tuberculosis____ Chlamydia____ Gonorrhea_____ Syphilis_____

TURN OVER AND CONTINUE ON THE OTHER SIDE

Review of Systems

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

CONSTITUTIONAL		**GASTROINTESTINAL**	
Developmental Disability	Yes/No	Crohn's Disease	Yes/No
Cancer	Yes/No	Colitis	Yes/No
Weight Loss/Gain	Yes/No	Ulcer	Yes/No
EAR, NOSE, THROAT		Acid Reflux	Yes/No
Hearing Loss	Yes/No	Celiac Disease	Yes/No
Sinus Congestion	Yes/No	**GENITOURINARY**	
Dry mouth	Yes/No	Kidney Disease	Yes/No
NEUROLOGICAL		Prostate Disease/Cancer	Yes/No
Multiple Sclerosis	Yes/No	Benign Prostate Hypertrophy	Yes/No
Epilepsy	Yes/No	**MUSCULOSKELETAL**	
Cerebral Palsy	Yes/No	Rheumatoid Arthritis	Yes/No
Tumor	Yes/No	Osteoarthritis	Yes/No
Stroke/CVA	Yes/No	Fibromyalgia	Yes/No
Migraine	Yes/No	Muscular Dystrophy	Yes/No
PSYCHIATRIC		Osteoporosis	Yes/No
Depression	Yes/No	Gout	Yes/No
Attention Deficit	Yes/No	**INTEGUMENTARY**	
Anxiety Disorder	Yes/No	Eczema	Yes/No
Bipolar Disorder	Yes/No	Rosacea	Yes/No
CARDIOVASCULAR		Psoriasis	Yes/No
Hypertension	Yes/No	Herpes Simplex/Cold Sores	Yes/No
Heart Disease	Yes/No	Herpes Zoster/Shingles	Yes/No
Vascular Disease	Yes/No	**ENDOCRINE**	
Congestive Heart Failure	Yes/No	Type 1 Diabetes Mellitus	Yes/No
RESPIRATORY		Type 2 Diabetes Mellitus	Yes/No
Asthma	Yes/No	Thyroid Dysfunction	Yes/No
Bronchitis	Yes/No	**HEMATOLOGIC/LYMPHATIC**	
Emphysema	Yes/No	Anemia	Yes/No
Sleep Apnea	Yes/No	High Cholesterol	Yes/No

Family History

Please note any family history for the following conditions:
(**Parents, Siblings, Children**)

DISEASE/CONDITION		**Relation**
Hypertension	Yes/No	_____
Diabetes -Type 1 or 2	Yes/No	_____
Cancer	Yes/No	_____
Thyroid	Yes/No	_____
Cataract	Yes/No	_____
Glaucoma	Yes/No	_____
Macular Degeneration	Yes/No	_____
Amblyopia (Lazy Eye)	Yes/No	_____
Strabismus (Crossed Eye)	Yes/No	_____
Retinal Detachment	Yes/No	_____
Other		_____

If you have answered YES or have one that is not listed, please explain and describe the problem.

_____

_____

_____

_____

CONSENT FOR TREATMENT: I/We hereby authorize Highpoint Family Vision to administer diagnostic and medical procedures as may be necessary for proper health care.

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECIEPT NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Highpoint Family Vision's statement on privacy practices.

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Highpoint Family Vision to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

MEDICARE AUTHORIZATION: I request payment of authorized Medicare benefits be made on my behalf to Highpoint Family Vision, for any service furnished to me by the doctor/supplier. I authorize the holder of medical information about me, to release to Medicare or any other insurance I may have and its agents any information needed to determine these benefits or the benefits payable to related services. In Medicare assigned cases, the doctor or supplier agrees to accept the charge determination of the Medicare carrier at full charge and the patient is responsible only for deductible, co-insurance and the uncovered services. Co-insurance and the deductible is based upon the charge determination of the Medicare carrier.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.

OFFICE POLICY on APPOINTMENTS: Missed appointments are subject to a $40 fee unless 24hr advanced notice is given.

_____ **Date** ____/____/____

Patient or Legal Guardian Signature

_____ **Date**____/____/____

Office Signature