ADVANCED ROCKFORD EYE CARE

MEDICAL HISTORY QUESTIONNAIRE

***Social Security needed only if we are submitting insurance on your behalf*
***This information is confidential and protected by patient privacy laws.*

Patient Information

Name______________________________ Date of Birth____/____/________
Address______________________________
City:______________________________State________Zip Code________________
E-Mail Address ______________________________
If married, full name of spouse: ______________________________
SS#: ______________/____________/____________
Home Phone: __________________ Cell Phone:______________________ Work Phone:________________
Occupation/place of employment:______________________________
Date of last Eye Exam:________/____/______ By Whom:______________________________
Primary Medical Doctor:______________________________Last Medical exam:___/_____/_____
Guardian (under 18): ______________________________
Whom may we thank for referring you? ______________________________
How did you hear about Advanced Rockford Eye Care?

What is your reason for today's exam? Please mark all that apply.

Itching	Broken Glasses	Blur At Distance	Blur with reading
Double vision	Floaters/Spots	Dryness	Flashes
Tearing/watering	Light sensitivity	Contacts	Cataracts
Mucous discharge	Lazy eye	Redness	Computer strain
Eye pain	Loss of side vision	Gritty feeling	Headache
Glaucoma	Other. If so explain	__________________	

Have you been previously diagnosed with an **eye related problem**?
If yes, explain______________________________
Have you ever had an **eye injury**?
If yes, explain______________________________
Have you had **eye surgery**?
If yes, explain______________________________
Do you *wear contacts*?
Do you *want contacts*?
Do you want *color contacts*?
Do you wear glasses:
Do you wish to purchase glasses today?
Do you wear sunglasses with 100% UVA/UVB?
Do you plan to buy prescription sunglasses today?

MEDICAL HISTORY

Please list all **Allergies**

____

Are you **pregnant** or nursing?
Are you taking any **medications**?
If Yes Please list:

____

____

List all major **injuries**, **surgeries** and/or hospitalizations:

____

Do you currently have, or have you ever been treated for any of the following*:*

High Blood Pressure	Headache/Migraines	Diabetes	Multiple sclerosis
Rheumatoid Arthritis	Seizures	Osteoporosis	Lupus
Thyroid/ Glands	Weight loss/gain	Anemia	Heart Disease
Crohn's / Colitis	HIV/ STD	Stroke	Anxiety/Depression
Osteoarthritis	Joint/Muscle pain	Allergies/Hay	High Cholesterol
Cancer	Asthma/Emphysema	Bronchitis	Psychiatric disorder
		Fever/Sinus	

Conditions not listed. Explain.____

FAMILY HISTORY:

Blindness	Cancer	Diabetes	Retinal Detachment
Sickle Cell Disease	Glaucoma	Color Blindness	Crossed/lazy Eyes
High blood pressure	Macular Degeneration	Heart Disease	Other

SOCIAL HISTORY

Do you use tobacco products?
Do you drink alcohol?
Do you have a history of recreational drug use?
If yes, explain:____

Insurance Authorization and Release of Information:

- I authorize Advanced Rockford Eye Care LLC to disclose medical records and/or information as may be necessary to process insurance claims and to obtain payment on my behalf. I authorize payment of my insurance benefits to Advanced Rockford Eye Care LLC.
- I understand that I will be responsible for any co-pays, unmet deductibles, or any balance not paid by my insurance plan.
- I also understand that eyeglasses and contact lenses are medical devices and once ordered are non-refundable and I will be responsible for payment in full.
- I have read and understand the HIPPA laws disclosed to me.

______________________________ ______________________________
Patient name | Legal Guardian Name (Printed) (If under 18)

______________________________ ______________________________
Patient/ (legal guardian) signature | Date

ADVANCED ROCKFORD EYE CARE

To be completed for children age 13 or younger.

Did your child fail a school screening?

If Yes, Please explain:____

Was your pregnancy full term?
If no, how many weeks premature?____

Where there any complications during or immediately following delivery?
If yes, explain:____

Does your child have a ***hearing*** deficit?
Does your child have a ***speech*** deficit?
Does your child have a ***sensory*** deficit

Does your child have any condition which prevents him/her from learning at his/her age level?
Please explain:
____
____

Has your child ever received the following? Yes No

Speech Therapy
Occupational Therapy
Physical Therapy
Vision Therapy

Please check any of the following which may be **TRUE** about your child:

____Avoids near work (reading/writing)

____Problems with reading comprehension

____Tilts or turns head with visual tasks

____Reverses letters when reading or writing

____Uses finger or pencil to keep place when reading

____Rubs eyes often while reading

____Has had special education testing or services

____Problems with attention or discipline

____School suggested eye exam

____Errors in copying from black board to paper

____School performance not up to potential

____Loses place, skips or re-reads works

____Complains of words running together

____Has had a consult with doctor/specialist regarding learning or behavior issues/learning