SOUTHWEST VISION

Dr Paul Gooch • Dr Ryan Robison • Dr Eric Drake

Medical History Questionnaire

Welcome to our office!

Name: _____ Gender: ☐Male ☐Female Today's date: _____

Address: _____ Cell Phone: _____

City, St, Zip: _____ Home Phone:_____

E-mail Address: _____ Work Phone: _____

What is the best way to communicate with you? ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

Birth Date: _____ SS#: (optional)_____

MEDICAL HISTORY

Previous Eye Doctor: _____ Last eye exam: _____

Medical Doctor: _____ Last medical: _____

Emergency Contact:_____ Phone:_____

Parents (if minor): _____ Spouse: _____

How did you find out about our office? ☐Physician: _____ ☐Referred by: _____

☐Insurance ☐Location ☐Phonebook ☐Radio ☐Internet ☐ Other: _____

Do you wear ☐ Glasses ☐ Soft Contact Lenses ☐ Hard Contact Lenses

Are your contact lenses comfortable: ☐ Yes ☐ No

Allergic to any prescription medications? ☐ No ☐ Yes (list) _____

List medications and supplements you are currently taking:		Dosage	How often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If more space is needed, please continue on the back of this page

Ocular History: _____ Injuries/Surgeries: _____

_____ _____

Currently pregnant or nursing? ☐ No ☐ Yes Delivery Date:_____

FAMILY HISTORY ☐ None ☐ Unknown/Adopted

Family Medical History: Note relation to yourself on the blank line (ex: mother, paternal grandmother, maternal grandfather, etc.)

Conditions/Relation

☐ Glaucoma _____	☐ Diabetes_____
☐ Macular Degeneration _____	☐ High Blood Pressure _____
☐ Retinal Detachment _____	☐ Thyroid Disease _____
☐ Cataract_____	☐ Heart Disease _____
☐ Crossed Eyes _____	☐ Cancer _____
☐ Blindness _____	☐ Other_____
☐ Unknown _____	☐ Unknown _____

LIFESTYLE HISTORY _____ (This information is kept confidential. You may discuss this portion directly with the doctor if you prefer)

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian
☐ Black or African American ☐ White

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Smoking Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker
☐ Never smoker ☐ Smoker, current status unknown ☐ Unknown if ever smoked

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 recreational drugs? ☐ No ☐ Yes If yes, type/amount/how long: _____

REVIEW OF SYSTEMS _____

Do you currently, or have you ever had any problems in the following areas? ❑ None

Eyes
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Cataract
- ❑ Lazy Eye/Amblyopia
- ❑ Vision Loss
- ❑ Crossed Eyes/Stabismus
- ❑ Dryness
- ❑ Color Blindness
- ❑ Double Vision
- ❑ Chronic Eye Infection
- ❑ Floaters/Flashes
- ❑ Blurred Vision

Allergic/Immunologic
- ❑ Seasonal Allergies

Musculoskeletal
- ❑ Arthritis
- ❑ Ankylosing Spondylitis

Cardiovascular
- ❑ Hypertension
- ❑ High cholesterol
- ❑ Heart Disease

Constitutional
- ❑ Fever
- ❑ Fatigue

Ears, Nose, Mouth, Throat
- ❑ Chronic Cough
- ❑ Sinus Congestion
- ❑ Dry Throat/Mouth

Endocrine
- ❑ Diabetes
  Year Diagnosed_____
- ❑ Thyroid Dysfunction

Gastrointestinal
- ❑ Irritable Bowel Syndrome
- ❑ Crohn's Disease

Genitourinary
- ❑ Kidney Problems
- ❑ Bladder Problems

Integumentary (skin)
- ❑ Rosacea
- ❑ Eczema

Lymphatic/Hematologic
- ❑ Anemia
- ❑ Bleeding Problems

Neurological
- ❑ Headaches
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Seizures

Psychiatric:
- ❑ ADHD
- ❑ Depression

Respiratory
- ❑ Asthma
- ❑ Emphysema
- ❑ Bronchitis

Please explain any items checked above and list any conditions not included above.

_____

_____

_____

Doctor's Signature:_____ Date:_____

Notice of Privacy Practices

I acknowledge that I have been offered a copy of the Notice of Privacy Practices

_____ _____

Signature Date

Financial Responsibility

- I authorize release of medical information regarding my treatment, to my insurance company, necessary for payment of services and materials provided by this office
- I authorize this office to accept assignment and receive payment directly from my insurance company, if billed
- If a patient balance remains for services or materials I may also be responsible for interest of 1.5% per month (18% per year)
- I understand there is a $28 service fee for returned checks
- I agree to pay all court costs and attorney fees, including charges and commissions up to 40% that may be assessed to us by any collection agency retained for delinquent accounts.

_____ _____

Signature Date

Release of Information (who do you want us to share any of your information with? Your spouse, child, etc.?)
I authorize release of my medical and billing information to

_____ Relationship:_____

This release is valid for ( ) 1 year ( ) 3 years ( ) until revoked

_____ _____

Signature Date

I have reviewed and updated, as needed, my Medical History Questionnaire

Visit 2 Patient signature:_____Date:_____
Visit 3 Patient signature:_____Date:_____
Visit 4 Patient signature:_____Date:_____
Visit 5 Patient signature:_____Date:_____
Visit 6 Patient signature:_____Date:_____
Visit 7 Patient signature:_____Date:_____
Visit 8 Patient signature:_____Date:_____
Visit 9 Patient signature:_____Date:_____
Visit 10 Patient signature:_____Date:_____