PATIENT HISTORY QUESTIONNAIRE

McCULLEY Optix Gallery

(Circle) Dr. Mr. Mrs. Ms. Miss. Date of Birth: ___/___/___ Age: _____

Name: _____ Preferred Name: _____
(First) (M.I) (Last)

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Cell: ☐ Y ☐ N Email: _____

Employer/Occupation: _____

How did you find us? _____

Payment is due at the time of service. Payment will be made via: ☐ Cash/Check ☐ Credit Card ☐ Insurance V M (Internal use)

PATIENT'S EYE HISTORY

Presenting Concerns Today: _____

_____

Do you wear glasses? ☐ Y ☐ N Do you wear contact lenses? ☐ Y ☐ N ☐ soft/disposable ☐ hard/rigid gas permeable

Have you ever worn contact lenses? ☐ Y ☐ N Are you interested in wearing contact lenses? ☐ Y ☐ N ☐ Possibly, tell me more

Are you planning to get new glasses today? ☐ Y ☐ N ☐ Maybe, depending on the exam

When was your last eye exam? _____ Where? _____

Check all that apply:

☐ Blurry vision	☐ Eye strain/fatigue	☐ Itchy eyes	☐ Red eyes	☐ Dry eyes
☐ Stinging/burning	☐ Watery eyes	☐ Flashes of light	☐ Floaters	☐ Eye Twitch

Please check any of the following conditions you have/had:

☐ Glaucoma ☐ Retinal Detachment ☐ Macular Degeneration ☐ Cataracts ☐ Dry Eyes ☐ Lazy Eye

Do you have any other eye conditions or problems? If so, describe _____

_____

Have you had LASIK? If so, when/where: _____

Have you had a serious infection, injury, or eye surgery? If yes, please describe and date: _____

_____

Are you using any eye drops (prescription or over-the-counter)? Please list: _____

_____

Continued on other side.

PATIENT MEDICAL INFORMATION

Do you currently, or have you had, any problems in the following areas? (✓) all that apply.

- ☐ Cardiovascular/Heart Disease
- ☐ Respiratory
- ☐ Blood/Lymph
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes (date of diagnosis: _____)
- ☐ Cancer
- ☐ Endocrine/Glands
- ☐ Thyroid
- ☐ Gastrointestinal
- ☐ Urinary Tract
- ☐ Ears/Nose/Throat
- ☐ Headache
- ☐ Nervous System
- ☐ Psychiatric/Physiological
- ☐ Muscles/Bones
- ☐ Integument/Skin
- ☐ Allergic/Immunologic

Please explain: _____

Other health problems: _____

Are you currently taking medication? ☐ Y ☐ N Please list: _____

Are you allergic to medication? ☐ Y ☐ N Please list: _____

FAMILY EYE & MEDICAL HISTORY

Please check (✓) any conditions that have occurred in your immediate family:

☐ No eye diseases in my family history

- ☐ Glaucoma Relation: _____
- ☐ Macular Degeneration Relation: _____
- ☐ Cataracts Relation: _____
- ☐ Retinal Detachment Relation: _____
- ☐ Diabetes Relation: _____
- ☐ High Blood Pressure Relation: _____

Other family eye or medical history: _____

Is there any physician you would like to have today's exam results sent to? _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I authorize the release of medical information regarding myself/my dependents and my current condition to my referring, consulting, or treating physicians.

Signature of Patient/Guardian: _____ Date: _____

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT:

We keep a record of the health care services we provide to you. This notice is available at your request. Your health information will be used only to treat you. We will not disclose your records to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. We will use your information to bill you insurance if necessary to receive payment for services or products. Our Notice of Privacy Practices is available at the reception desk. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Patient/Guardian: _____ Date: _____

FOR DOCTOR'S USE ONLY