BRANDYWINE EYE CENTER, P.A.

Please Print

MEDICAL HISTORY QUESTIONNAIRE

Patient's Legal Name: _____ How shall we address you? _____
Street Address: _____ Home Phone: _____
City _____ Cell Phone: _____
State _____ Zip _____ Work Phone: _____
SS#: _____ Date of Birth: ___/___/___ *Preferred Phone* (circle one:)
Marital Status (circle one) S / M / W Home / Cell / Work
Sex: M_____ F _____ E-mail: _____
Patient's Employer: _____ Occupation: _____
Spouse's Name: _____ Spouse's Work Phone _____
Spouse's Cell Phone _____ Emergency Contact Name and Phone(s): _____

_____

*Referring Physician: _____ Primary Care Physician: _____
Optometrist: _____ Specialty Care Physician(s): _____
*Pharmacy: _____ Location: _____
*Who should we thank for referring you? Name: _____
Reason for Visit: _____

INSURANCE INFORMATION:

Is this condition related to: Employment? (circle one) Y / N Auto Accident? Y / N Other Accident? Y / N
Medicare #: _____
Additional Insurance Name: _____
Claim Office Address: _____
ID # / Policy #: _____ Group #: _____
Policy Holder's Name: _____ Sex: M_____ F_____
Address: _____ Phone #: _____
Relationship of Patient to Policy Holder _____ Date of Birth: ___/___/___
Is Policy Holder's insurance provided by an employer or previous employer? Yes _____ No _____
Which is primary? (Circle one:) Medicare / Other

Race: (please check one)
❑ American Indian or Alaska Native
❑ Native Hawaiian or Other Pacific Islander
❑ Black or African American
❑ Asian ❑ White

Preferred Language:
❑ English ❑ Portuguese ❑ Japanese
❑ French ❑ Russian ❑ Spanish
❑ Italian ❑ Other _____

Ethnicity: (please check one) ❑ Hispanic ❑ Not Hispanic

I request that payment of authorized medical insurance benefits be made either to me or on my behalf to Brandywine Eye Associates, P.A. for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

MEDICARE PATIENTS ONLY:
I understand that the refraction portion of any complete eye examination is not covered for payment by Medicare.

Signature: _____ Date: _____

PAST OCULAR / MEDICAL HISTORY

ALLERGIES:	REACTION:	SEVERITY (CIRCLE ONE)
		mild / moderate / severe
		mild / moderate / severe
		mild / moderate / severe
		mild / moderate / severe
		mild / moderate / severe

PAST OCULAR HISTORY	PAST OCULAR SURGERIES

PAST MEDICAL HISTORY	PAST SURGERIES

FAMILY HISTORY

❑ Diabetes ❑ Stroke ❑ Blindness ❑ Macular Degeneration ❑ Arthritis
❑ Cancer ❑ TB ❑ Cataracts ❑ Retinal Disease ❑ Lazy Eye
❑ Heart Disease ❑ Kidney Disease ❑ Glaucoma ❑ High Blood Pressure
❑ Other / explanation _____

_____

SOCIAL HISTORY

Smoking: ❑ Yes ❑ No ❑ If yes, when started? _____When Quit? _____

Alcohol: ❑ Yes ❑ No ❑ If yes, how much? _____

Drugs: ❑ Yes ❑ No ❑ If yes, drugs used? _____

How much? _____How long? _____When quit?_____

MEDICINE RECONCILIATION

Please put the number that best describes the route of administration of your medication in the Route column.
#1 By Mouth **#2** Eye Drop **#3** Nasal Spray **#4** Injection or IV Pump **#5** Other

CURRENT OCULAR MEDICATIONS:

Medication	Dosage	Frequency	Route

CURRENT SYSTEMIC MEDICATIONS & VITAMINS:

Medication	Dosage	Frequency	Route

Please sign _____*Date* _____

REVIEW OF SYSTEMS

Eyes
Previous Surgery ❑ Yes ❑ No
Contact Lens ❑ Yes ❑ No
Pain ❑ Yes ❑ No
Double Vision ❑ Yes ❑ No
Glaucoma ❑ Yes ❑ No
Cataracts ❑ Yes ❑ No
Macular Degeneration ❑ Yes ❑ No
Dry Eyes ❑ Yes ❑ No
Blurry Vision ❑ Yes ❑ No

Ear, Nose and Throat
Hard of Hearing ❑ Yes ❑ No
Ringing in Ears ❑ Yes ❑ No
Vertigo ❑ Yes ❑ No

Cardiovascular
Chest Pain ❑ Yes ❑ No
Dizziness ❑ Yes ❑ No
Fainting Spells ❑ Yes ❑ No
Shortness of Breath ❑ Yes ❑ No
Irregular Heart Beat ❑ Yes ❑ No
Difficulty Lying Flat ❑ Yes ❑ No

Constitutional
Fatigue Fever ❑ Yes ❑ No
Fever ❑ Yes ❑ No
Previous Surgery ❑ Yes ❑ No

Respiratory
Tuberculosis ❑ Yes ❑ No
Cough ❑ Yes ❑ No
Congestion ❑ Yes ❑ No
Wheezing ❑ Yes ❑ No
Asthma ❑ Yes ❑ No

Gastrointestinal
Heartburn ❑ Yes ❑ No
Nausea/Vomiting ❑ Yes ❑ No
Jaundice/Hepatitis ❑ Yes ❑ No

Genito-Urinary
Pain/Difficulty ❑ Yes ❑ No
Blood in Urine ❑ Yes ❑ No
History of Kidney Stones ❑ Yes ❑ No
History of STD's ❑ Yes ❑ No

Psychiatric
Anxiety/Depression ❑ Yes ❑ No
Mood Swings ❑ Yes ❑ No
Difficulty Sleeping ❑ Yes ❑ No

Endocrine
Increased Thirst ❑ Yes ❑ No
Increased Hunger ❑ Yes ❑ No
Increased Urination ❑ Yes ❑ No
Increased Sweating ❑ Yes ❑ No
Fingernail Changes ❑ Yes ❑ No

Blood/Lymphnodes
Easy Bruising ❑ Yes ❑ No
Gums Bleed Easily ❑ Yes ❑ No
Prolonged Bleeding ❑ Yes ❑ No
Heavy Aspirin Use ❑ Yes ❑ No

MusculoSkeletal
Stiffness ❑ Yes ❑ No
Arthritis ❑ Yes ❑ No
Joint Pain/Swelling ❑ Yes ❑ No

Skin
Rash/Sores ❑ Yes ❑ No
Lesions ❑ Yes ❑ No
Hives/Eczema ❑ Yes ❑ No

Neurological
Seizures ❑ Yes ❑ No
Weakness/Paralysis ❑ Yes ❑ No
Numbness ❑ Yes ❑ No
Tremors ❑ Yes ❑ No

Immunologic
Hives ❑ Yes ❑ No
Itching ❑ Yes ❑ No
Runny Nose ❑ Yes ❑ No
Sinus Pressure ❑ Yes ❑ No

Notes: _____

PATIENT CONSENT FORM

Our Notice of Privacy Practices (September 2013 revision) provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations, including appointment reminders by postcard or messages on an answering machine.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent allows the practice to disclose any information to the following people:

Spouse _____ Parents _____

Children _____

Other _____

(Please print the names of the individuals)

_____

Patient or Representative

Relationship to Patient (if other than patient): _____ Date: _____

In front of _____

Practice representative