MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date ___/___/___ Date of Birth ___/___/___

Last Eye Exam (if new patient) ___/___/___ Previous Eye Doctor (if new patient) _____

General Surgeries (please circle all that apply): TONSILLECTOMY ▪ APPENDECTOMY ▪ KNEE/HIP REPLACEMENT HEART/BYPASS/STENT ▪ TRANSPLANT ▪ OTHER _____

Eye Surgeries (please circle all that apply): LID LIFT ▪ EYE MUSCLE SURGERY ▪ LASIK ▪ CATARACT REMOVAL LASER FOR GLAUCOMA ▪ LASER FOR DIABETES RETINAL DETACHMENT/TEAR REPAIR ▪ OTHER _____

CURRENT SYMPTOMS (please circle all that apply)

LOSS OF VISION (BLACKOUTS) BLUR HALOS/GLARE LOSS OF SIDE VISION DOUBLE VISION
DRYNESS MUCOUS DISCHARGE REDNESS SANDY/GRITTY ITCHING
BURNING WATERY PAIN/SORENESS TIRED EYES CROSSED EYES
LAZY EYE DROOPING LIDS SPOTS/FLOATERS FLASHES OF LIGHT HEADACHE
DIFFICULTY DRIVING AT NIGHT OTHER:

MEDICAL HEALTH HISTORY: Please circle any of the below conditions that apply to YOU

EYE: CATARACTS, GLAUCOMA, MACULAR DEGENERATION, RETINAL DETACHMENT, LASER VISION CORRECTION, OTHER:

EAR, NOSE, THROAT: SINUS, EAR INFECTION, CHRONIC COUGH, SLEEP APNEA, OTHER:

HEART: HIGH BLOOD PRESSURE, HEART ATTACK, BYPASS, STENT, VALVE, OTHER:

LUNGS: ASTHMA, EMPHYSEMA, COPD, OTHER:

GENITAL, KIDNEY, BLADDER: INCONTINENCE, KIDNEY STONES, IMPOTENCE, OTHER:

GASTROINTESTINAL: ACID REFLUX, ULCER, IBS, OTHER:

MUSCLES, BONES, JOINTS: ARTHRITIS, RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOPOROSIS, OTHER:

SKIN: ACNE, WARTS, SKIN CANCER, ROSACEA, OTHER:

BRAIN: MULTIPLE SCLEROSIS, STROKE, PARALYSIS, TUMOR, HEADACHES, OTHER:

PSYCHIATRIC: ANXIETY, DEPRESSION, INSOMNIA, OTHER:

ENDOCRINE: DIABETES, HYPOTHYROID, HYPERTHYROID, OTHER:

BLOOD/LYMPH: HIGH CHOLESTEROL, ANEMIA, LEUKEMIA, OTHER:

ALLERGIC/IMMUNOLOGIC: HAY FEVER, LUPUS, SJOGRENS, LYME, OTHER:

INFECTIOUS DISEASE: HIV, HEPATITIS, TUBERCULOSIS, AIDS, OTHER:

OTHER:

FAMILY HISTORY: Please circle category in which a FAMILY MEMBER has a condition/disease

EYE ♦ EAR, NOSE, THROAT ♦ HEART ♦ LUNGS ♦ GENITAL, KIDNEY, BLADDER

GASTROINTESTINAL ♦ MUSCLES, BONES, JOINTS ♦ SKIN ♦ BRAIN ♦ PSYCHIATRIC

ENDOCRINE ♦ BLOOD/LYMPH ♦ ALLERGIC/IMMUNOLOGIC ♦ INFECTIOUS DISEASE ♦ OTHER

SOCIAL HISTORY

Occupation: _____ **Hobbies:** _____

Education: (circle one) Elementary ▪ High School Vo-Tech ▪ College ▪ Graduate School

Marital Status: (circle one) Married ▪ Single Widowed ▪ Divorced

Drive? Y ▪ N

Do you drink alcohol? Y ▪ N If yes: Occasional ▪ 1/Day ▪ 2-3/Day ▪ 4+/Day

Do you smoke? Y ▪ N If yes: Occasional ▪ ½ Pack/Day ▪ 1 Pack/Day ▪ 1+Pack/Day

Family Medical Doctor: _____ Patient init. _____ Dr. init. _____

WYOMISSING OPTOMETRIC CENTER, INC.

INFORMATION SHEET

The following information is requested to eliminate potential accounting and/or insurance problems. Your cooperation in completing this form is greatly appreciated.

PATIENT INFORMATION (Please Print)

LAST NAME	FIRST	MIDDLE INITIAL	SEX

STREET ADDRESS	CITY	STATE

ZIP CODE	HOME PHONE	WORK PHONE EXT.	☐ MR. ☐ MRS. ☐ MS. ☐ MISS ☐ DR.

BIRTHDATE	EMAIL ADDRESS	RELATIONSHIP TO GUARANTOR	REFERRED BY

SCHOOL	SOCIAL SECURITY NUMBER

OCCUPATION	EMPLOYER

GUARANTOR INFORMATION (Person Financially Responsible)

LAST NAME	FIRST	BIRTHDATE

STREET ADDRESS	CITY	STATE

ZIP CODE	HOME PHONE	WORK PHONE EXT.	☐ MR. ☐ MRS. ☐ MS. ☐ MISS ☐ DR.

EMPLOYER	EMPLOYER'S ADDRESS	PHONE	SOCIAL SECURITY NUMBER

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ OTHER _____

INSURED PERSON'S INFORMATION

NAME	BIRTHDATE

EMPLOYER	ID #

PATIENT PAYMENT RESPONSIBILTY AGREEMENT

It is our policy that all fees be paid at the time of service. As a courtesy to our patients, we will complete and file INSURANCE FORMS related to services provided in our office. Please be aware that *not all* services are covered by insurance and *noncovered fees,* co-pays and deductibles are the responsibility of the patient. Your contract is between you and your insurance carrier. It is not our responsibility to contact your insurance company with regard to payment or nonpayment of your bill. We will allow six (6) weeks for the payment of fees submitted to your insurance company, at which time payment will become your responsibility. Should your insurance carrier send payment directly to you, we require that you send or deliver this payment to our office within five (5) days of receipt.

For all insured and non-insured patients:

"Should it be necessary to turn my account over to a collection agency, I agree to pay a collection fee of $20.00, court costs and reasonable attorney's fees in addition to the balance due.

This agreement is expressly written to cover services rendered and/or materials dispensed today and on any subsequent visits to WYOMISSING OPTOMETRIC CENTER, INC. It is agreed and understood that the guarantor agrees to these terms."

"I hereby authorize WYOMISSING OPTOMETRIC CENTER, INC. to furnish information to my insurance company concerning my care and authorize my insurance company to pay WYOMISSING OPTOMETRIC CENTER, INC. directly for covered services."

GUARANTOR
(Person financially responsible)

PATIENT / PARENT / LEGAL GUARDIAN

DATE

ACCOUNT #

(OVER)