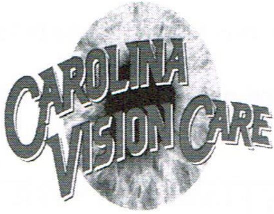

Welcome To Our Office

Thank You for visiting *Carolina Vision Care* for your eye care needs. Please *complete* this *confidential* and *private* **Medical History Questionnaire** it will help us to provide you with the best eye care possible. Please answer all questions as neatly and completely as you can **(please fill out FRONT and BACK of this form)**. Please be reassured that all information in your medical record is *private* and will be confidential, unless you give written authorization for it to be released.

Patient Information

Patient's Full Name: Mr./Mrs./Ms./Dr. ____
First Middle Last

Home Address: ____
Street or P.O. Box City State Zip

Home Phone: ______________________ Work Phone: ____________________ Cell Phone: __________________

❑ Male ❑ Female Birth Date: _____/_____/_____ Age: _______ Social Security # _______/______/______

Employer: ______________________________ Spouse's/Parent/Guardian's Name: _________________________

How were you referred to this office? (Friend/Family Member Advertisement) ______________________________

Who is responsible for account? ____
Name Phone Number Relationship to patient

Insurance Company: ______________________ Policy Holder's Information: ____________________________
Name Name Birth Date

PLEASE SHOW ALL INSURANCE CARDS TO THE RECEPTIONIST BEFORE YOUR EXAM
ALL CO-PAYS OR BALANCES ON SERVICES NOT COVERED BY YOUR INSURANCE WILL BE DUE TODAY

Lifestyle: Your occupation and lifestyle play a very important role in determining your visual requirements. How you will use your eye wear directly affects their performance.

What is you,occupation? ____

Do you use a computer? ❑ Yes ❑ No If yes, how many hours a day? ______________________________

What hobbies or activities do you enjoy? ____

Medical History:

Please Check (✓) the problem(s) .with your eyes/vision since your last visit with *Carolina Vision Care*.

❑**Blurred Distance Vision**	❑**LoslBroken Glasses**	❑**Water Discharge**	❑**Mucous Discharge**
❑**Blurred Near Vision**	❑**Contact Lenses**	❑**Floaters**	❑**Red Eyes**
❑**Poor Night Vision**	❑**Dry Eyes**	❑**Headaches**	❑**Eye Pain**
❑**Double Vision**	❑**Eye Injury**	❑**Light Sensitive**	❑**No Complaints**

Name of Primary Medical Doctor__________________ Date of last medical exam _________________________

Would you like for us to send results of your eye exam today to you, primary doctor?(Y/N)____________________

*****Please Turn Over And Complete The Other Side*****

Do you currently have, or have you or immediate family such as parents, grandparents. brother. or sister, ever had any of the following conditions?

If yes for the patient please (✓) the condition under the "SELF" column. If yes for a family member, please list their relation to you under the "FAMILY MEMBER" column.

CONDITION	SELF (✓)	FAMILY MEMBER	CONDITION	SELF (✓)	FAMILY MEMBER
Arthritis			**High Blood Pressure**		
Asthma			**High Cholesterol**		
Bleeding Disorders			**Liver Disease**		
Cancer			**Lung Disease**		
Cataracts			**Lupus**		
Diabetes			**Macular Degeneration**		
Dry Eyes			**Retinal Detachment**		
Epilepsy			**Seasonal Allergies**		
Glaucoma			**Thyroid Disease**		
Heart Disease			**Other**		

Please check Yes or No

Do you smoke? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No

Do you use recreational drugs? ❑ Yes ❑ No

Me you currently pregnant or nursing a child? ❑ Yes ❑ No

Have you been diagnosed with HIV/AIDS? ❑ Yes ❑ No

Please **list all medications** (prescription and over-the counter) that you are currently taking ______________________________

____

Please list all past **major surgeries** (including eye surgeries): ______________________________

____

Are you **allergic** to any **medications**? ❑ Yes ❑ No *Please list:* ______________________________

Have you ever had an **adverse reaction** to having your **eyes dilated**? ❑ Yes ❑ No

Date of Last Eye Exam ____________ Previous Eye Doctor ______________________ Age of current glasses?__________

Are you interested in wearing contacts? ❑ Yes ❑ No

Which do you wear most? ❑ Glasses ❑ Contact Lenses

Contacts: Type (please circle): Soft Hard Gas Permeable Toric Disposable ______________________

How often do you dispose of (or replace) your contact lenses? __________ What brand of solution do you use? ______________

How many hours per day do you wear your contacts? ___________ Do you sleep in your contacts? ❑ Yes ❑ No

If yes, how long do you wear your contacts before taking them out overnight? ________________

By signing below the patient/guardian gives Carolina Vision Care:

1. Authority to release necessary information to process an insurance claim on your behalf.
2. Grants authority for the examining to administer necessary exam procedures and tests for the patient's visit.
3. Understands that the patient/guardian is responsible for all charges whether or not paid by their insurance company.
4. Understands that should the account become delinquent and require collection services, the patient/guardian agrees to pay collection and handling fees (including attorney fees) and that a billing fee per monthly billing statement will be added to any account delinquent over 30 days.
5. A $30.00 fee (or maximum allowed by law) will be charged on all returned checks.
6. I acknowledge that I have been offered a copy of Carolina Vision Care's Privacy Practices,

____

Patient (Guardian) Signature **Date**