BROBERG EYE CARE MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________ Nickname: ______________ DOB: ___/___/_____

Primary Care Physician: ____________________ Referring/Specialty Dr.____________________

Pharmacy [including address & phone #]: ______________________________________

Required for Electronic Medical Records

Race: ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American**

☐ **Native Hawaiian or Other Pacific Islands** ☐ **White or Caucasian** ☐ **Latin**

Ethnicity: ☐ **Hispanic** ☐ **Not Hispanic**

Preferred Language: ☐ **English** ☐ **Spanish** ☐ **Other** ____________________

Allergies: [Drug or Medical]

____ Drug Allergy or Drug Intolerance?

____ Drug Allergy or Drug Intolerance?

Past Ocular History: (Please mark all that apply.) ☐ None

☐ Cataracts
☐ Amblyopia (Lazy eye)
☐ Optic Neuritis
☐ Aphakia
☐ Glaucoma
☐ Other____

☐ Hyperopia (Far sighted)
☐ Diabetic Retinopathy
☐ Dry Eyes
☐ Retinal Detachment
☐ Macular Degeneration

☐ Myopia (Near sighted)
☐ Iritis
☐ Keratoconus
☐ Astigmatism
☐ Strabismus (Eye turned in/out)

Ocular Surgeries/Procedures: (Please mark all that apply)

	Right	Left		Right	Left
☐ No prior ocular surgery	☐	☐	☐ Foreign body removal	☐	☐
☐ Punctal Plugs	☐	☐	☐ Trabeculectomy (Glaucoma Surgery)	☐	☐
☐ Blepharoplasty	☐	☐	☐ Retinal Laser Surgery	☐	☐
☐ RK	☐	☐	☐ Vitrectomy	☐	☐
☐ Cataract Surgery	☐	☐	☐ Strabismus Surgery	☐	☐
☐ Lasik / PRK	☐	☐	☐ Corneal Transplant	☐	☐
☐ Yag Capsulotomy	☐	☐	☐ Yag Peripheral Iridotomy	☐	☐
☐ Other________________________________				☐	☐

Current Eye Medications: (Please List): ☐ None

____

____

____

Have you **EVER** used Flomax? ☐ Yes ☐ No

Systemic Illnesses: ☐ NONE

☐ Anemia	☐ Hepatitis A/B/C	☐ Meningitis
☐ Arrhythmia	☐ Herpes Simplex	☐ Migraine
☐ Arthritis	☐ Herpes Zoster / Shingles	☐ MRSA
☐ Asthma	☐ High Cholesterol	☐ Multiple Sclerosis
☐ Bleeding Disorder	☐ High Blood Pressure	☐ Polymyalgia
☐ Cancer	☐ Histoplasmosis	☐ Psychiatric Disorder
☐ Chicken Pox	☐ HIV/ AIDS	☐ Rheumatoid Arthritis
☐ Congestive Heart Failure	☐ Hyperthyroidism	☐ Sjogrens
☐ COPD	☐ Hypothyroidism	☐ Skin Cancer
☐ Diabetes	☐ Kidney Disease	☐ Stroke
☐ Eczema	☐ Kidney Stones	☐ Syphilis
☐ Fibromyalgia	☐ Liver Disease	☐ Toxoplasmosis
☐ Graves Disease	☐ Lung Disease	☐ Wound Infection
☐ Hearing Loss	☐ Lupus	

☐ Other ______________________________

General Surgeries/Operations: (Please list) ☐ None

____
____
____

Current Other/Non Eye Medications: (Please list) ☐ None

____
____
____

Family History: ☐ None

☐ Diabetes	☐ Stroke	☐ Blindness	☐ Macular Degeneration
☐ Cancer	☐ TB	☐ Cataracts	☐ Retinal Disease
☐ Heart Disease	☐ Kidney Disease	☐ Glaucoma	☐ High Blood Pressure
☐ Arthritis	☐ Lazy Eye		

Other______________________________

Social History: (Please mark all that apply)

Smoking: ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never smoked

Alcohol Use: ☐ Yes ☐ No If yes how much and how often?________________________________

Drug Use: ☐ Yes ☐ No If yes what and how often?______________________________________

Review of Systems [Current]:

Eyes

Previous Surgery ☐ Yes ☐No
Contact Lens ☐ Yes ☐ No
Pain ☐ Yes ☐ No
Double vision ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No
Macular Degen ☐ Yes ☐ No
Dry Eyes ☐ Yes ☐ No
Flashes ☐ Yes ☐ No
Floaters ☐ Yes ☐ No

Respiratory

Cough ☐ Yes ☐ No
Congestion ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No
Asthma ☐ Yes ☐ No

Blood /Lymph Nodes

Easy bruising ☐ Yes ☐ No
Gums Bleed Easy ☐ Yes ☐ No
Prolonged Bleeding ☐ Yes ☐ No
Heavy Aspirin Use ☐ Yes ☐ No

Gastrointestinal

Heartburn ☐ Yes ☐ No
Nausea/Vomiting ☐ Yes ☐ No
Jaundice/Hepatitus ☐ Yes ☐ No

Musculo Skeletal

Stiffness ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Joint Pain/Swelling ☐Yes ☐ No

Ear, Nose and Throat

Hard of Hearing ☐ Yes ☐ No
Ringing in Ears ☐ Yes ☐ No
Vertigo ☐ Yes ☐ No
DEAF ☐ Yes ☐ No

Genito-Urinary

Pain/Difficulty ☐ Yes ☐ No
Blood in Urine ☐ Yes ☐ No
Kidney Stones ☐ Yes ☐ No
History of STD's ☐ Yes ☐ No

Skin

Rash/Sores ☐ Yes ☐ No
Lesions ☐ Yes ☐ No
Hives ☐ 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

Psychiatric

Anxiety/Depression ☐ Yes ☐ No
Mood Swings ☐ Yes ☐ No
Difficulty Sleeping ☐ Yes ☐ No

Neurological

Seizures ☐ Yes ☐ No
Weakness/Paralysis ☐ Yes ☐ No
Numbness ☐ Yes ☐ No
Tremors ☐ Yes ☐ No

Constitutional

Fatigue/Weakness ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Weight Gain/Loss ☐ Yes ☐ No

Endocrine

Increased Thirst ☐ Yes ☐ No
Increased Hunger ☐ Yes ☐ No
Increased Urination ☐ Yes ☐ No
Increased Sweating ☐ Yes ☐ No
Fingernail Changes ☐ Yes ☐ No

Immunologic

Hives ☐ Yes ☐ No
Itching ☐ Yes ☐ No
Runny Nose ☐ Yes ☐ No
Sinus Pressure ☐ Yes ☐ No

BROBERG EYE CARE

PATIENT INFORMATION

Full Name___First_______________________________MI_____________________Last________________________

Date of Birth_____/_____/_____ Social Security Number_______________________ Sex: M F

Home Phone (_______)___________________Cell / Work Phone (_______)____________________

Street Address_____________________________ City_______________ State_____ Zip__________

Mailing Address____________________________ City_______________ State_____ Zip__________

Employer_________________________________ Address______________________________

Marital Status: S M D W Spouse's Name____________________ Spouse's Employer______________

If Patient is a minor, name of Guarantor__________________________ Relationship______________

FAMILY MEMBERS/EMERGENCY CONTACTS

Names of other family members who have been seen here as patients:

____ Doctor Seen____________________

____ Doctor Seen____________________

Emergency contact name______________________ Phone (_____)___________ Relationship__________

I hereby authorize BROBERG EYE CARE to release any information regarding my illness and treatment to the following person(s)____ Phone (_______)__________

REFERRED BY

PLEASE INDICATE HOW YOU WERE REFERRED TO OUR PRACTICE

_______I was referred by another EYE DOCTOR, Dr.____________________

_______I was referred by my doctor, Dr.___________________________

_______I was referred by a friend or family member____________________

_______Internet: (please check one) ____our website ____Yelp ____ Angie's List___Google ____Other______________

_______Other____

INSURANCE INFORMATION

Primary Insurance Carrier_________________________ Subscriber's Name__________________________

Subscriber's SSN_____________________ Date of Birth_____________ Relationship to Patient__________

Secondary Insurance Carrier_______________________ Subscriber's Name__________________________

Subscriber's SSN_____________________ Date of Birth_____________ Relationship to Patient__________

RESPONSIBLE PERSON

Who is responsible for payment: ______Patient ______Parent ______Other

Responsible Person's Name_______________________________ Relationship to Patient______________

Home Phone (_______)_________________ Cell / Work Phone (_______)____________________

Address_______________________________________ City____________ State________ Zip__________

TREATING DOCTORS

Primary Care Doctor_____________________________________ Phone (_______)__________________

Specialist Doctor_______________________________________ Phone (_______)__________________

Other____ Phone (_______)__________________

OFFICE POLICY ON STANDARD AND MANAGED CARE INSURERS

In order to accommodate the needs and requests of our patients, we are enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of each plan. Each one has different stipulations regarding how often services may be rendered, what services can be provided, and what services may be performed on the same day as an office visit. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you **let us know at EACH time of service exactly what those guidelines are.** Unfortunately, if you do not inform us of any special requirement in your contract and we subsequently provide services that are not covered by your insurance, we will have no choice but to bill you directly for those charges. **Payment for those charges is then your responsibility.**

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to do what we do best, **concentrate on caring for your medical needs.**

1. Payment of co-pays/deductibles is required **at the time services are provided.**
2. PPO and HMO participants are responsible for obtaining necessary referrals prior to appointment.
3. Unauthorized or unreferred services will be the responsibility of the patient.
4. A refraction is a measurement for a glasses prescription. Most insurances do not cover this charge. If the test is done during the exam and denied by insurance, the charge will be billed to the patient.

We file insurance claims with all contracted PPO and HMO's. A copy of your insurance card and assignment of benefits is required. Remaining balances after your insurance pays is your responsibility. Any questions regarding a processed claim should be directed to your insurance carrier. If you feel your insurance company has processed your claim incorrectly, **follow-up with your insurance carrier for reconsideration of your claim is your responsibility.**

I have read and understand the office policy stated above and agree to accept responsibility as described.

Signed____ Date__________________________

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION / HIPAA NOTICE

I have requested medical services from Broberg Eye Care on behalf of myself and/or my dependents. I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I understand that if I fail to provide all necessary information to file my insurance claim, I will be required to pay all charges in full at the time services are rendered. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment to BROBERG EYE CARE for medical services rendered to myself and/or my dependents. I authorize BROBERG EYE CARE to release any information necessary to insurance carriers regarding my illness and treatment for the processing of any claims. I have been made aware of and/or reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Patient/Responsible Party Signature______________________________________ Date__________________