

Patient Medical History Questionnaire



DR. GUY T. McDOUGAL
AND ASSOCIATES, P.C.

Patient Name _____ Male Female Today's Date _____
Last First Middle Initial mo/day/yr
Address _____ Space/Apt # _____ City/State _____ Zip _____
Home Phone _____ Cell _____ Email _____ Social Security # _____
Birth Date _____ Age _____ Responsible Party _____ Last Eye Exam _____
Mo/day/yr mo/yr Doctor Providing Exam
Nearest Relative Not Living With You _____ Relationship _____ Phone _____
Name and Address
 Yes - Full Time Arizona Resident No - Part Time Resident Please provide a secondary address and contact telephone number:

Insurance Information

Please present Insurance/Medicare cards at front desk to have scanned into records.

- N Y Vision Insurance? Name: _____
- N Y Primary Medical Insurance? Name: _____
- N Y Do you have a Medicare card? Who is your Secondary Insurance? _____
- N Y Have you assigned your Medicare benefits over to another company? Who? _____

Medical History

If you have a written medications list, please give to front desk to have scanned into records.

- N Y Are you pregnant and/or nursing?
- N Y Allergies to medications? Explain: _____
- List any medications you take: (Including Vitamins, OTC Products and Oral Contraceptives):

- List any ocular medication you take: (Eye medications): _____

Contact Lens Information

- N Y Do you wear contact lenses?
- Type of lenses? _____
- Replaced how often? _____
- N Y Are your contacts comfortable?
- N Y Any problems with your current contact lenses? Explain: _____

Glasses Information

- N Y Do you wear glasses?
- N Y Are you considering refractive Surgery/LASIK? When? _____
- N Y Do you have Dry Eyes?
- N Y Do you use Artificial Tears?
- Number of hours per day on a computer: _____

Family History

19. Please check any family history (parents, grandparents, siblings, children: living or deceased) for the following:

Disease/Condition	Family Relation	Disease/Condition	Family Relation
<input type="checkbox"/> Blindness	_____	<input type="checkbox"/> Arthritis/Lupus	_____
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Crossed Eyes	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Mac. Degeneration	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Retinal Problems	_____	<input type="checkbox"/> Thyroid Disease	_____
<input type="checkbox"/> None of these		<input type="checkbox"/> None of these	

Social History

This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.

Yes, I would prefer to discuss my Social History Information directly with my doctor (check box).

- N Y Do you drive?
- N Y If yes, do you have visual difficulty when driving? Explain: _____
- N Y Do you use tobacco products? If yes, type/amount/how long: _____
- N Y Do you drink alcohol? If yes, type/amount/how long: _____
- N Y Do you use illegal drugs? If yes, type/amount/how long: _____
- Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None of these

Personal Ocular History

Please explain if you have a condition not listed: _____

- Check any of the following conditions you have had:

<input type="checkbox"/> Allergy Eyes	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Prominent Eyes
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Retinal Disease
<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Eye Injuries	<input type="checkbox"/> Lazy Eye	<input type="checkbox"/> None of these
<input type="checkbox"/> Drooping Eyelid	<input type="checkbox"/> Eye Surgery		

Personal Medical History

27. Check any chronic problems you have had in the past or currently have:

Allergic/Immunologic

- allergic/immunologic

Bones/Joints/Muscles

- rheumatoid arthritis
 muscle pain

Constitutional

- fever, weight loss/gain

Ears, Nose, Mouth, Throat

- allergies/hay fever
 sinus congestion
 runny nose
 post-nasal drip
 chronic cough
 dry throat/mouth

Endocrine

- thyroid/other glands

Eyes

- permanent loss of vision
 blurred vision
 distorted vision/halos
 loss of side vision

- double vision
 dryness
 mucous discharge
 redness
 sandy or gritty feeling
 itching
 burning
 foreign body sensation
 excess tearing/watering
 glare/light sensitivity
 eye pain or soreness
 infection of eye lid
 styes or chalazion
 floaters in vision
 light flashes

Gastrointestinal

- diarrhea
 constipation

Genitourinary

- genitals/kidney/bladder

Integumentary (skin)

- integumentary (skin)

Lymphatic/Hematologic

- anemia
 bleeding problems

Neurological

- headaches
 migraines
 seizures

Psychiatric

- psychiatric

Respiratory

- asthma
 chronic bronchitis
 emphysema

Vascular/Cardiovascular

- diabetes
 heart pain
 high blood pressure
 vascular disease

I HAVE NONE OF THE ABOVE CONDITIONS.

28. If you checked any of the above conditions or have a condition not listed, please explain below:

Please note:

- Professional fees are not refundable.
- Medicare will not pay for refractive services or routine care. If submitted to Medicare, you will likely be denied reimbursement.
- Prescription rechecks available at no charge for 30 days from original exam by original doctor. Fees apply after 30 days or for second opinion.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

- I authorize the release of any medical or any other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment: Dr. Guy T. McDougal and Associates, P.C.
- I authorize payment of medical benefits to Dr. Guy T. McDougal and Associates P.C. for services rendered. I agree to be financially responsible for any balance not paid by my insurance plan.

HIPAA REGULATIONS

- In compliance with HIPAA regulations, all of your information will be kept confidential. I have been presented with the Notice of Privacy Policy of Dr. Guy T. McDougal and Associates, P.C. (the "provider") and have been offered a copy of such policy for my records.

Printed Name of Patient
OR Patient's Representative

Signature of Patient
OR Patient's Representative

Relationship to Patient
(Only indicate if representative)

Date

For office use only:

Doctor's signature: _____

Date: _____