

WABASH VALLEY EYE CENTER/SURGERY CENTER
MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: ____/____/____ Age: _____
 Address: _____ City, State: _____
 Phone _____ Cell Phone _____
 Medical Doctor: _____ City, State: _____
 Pharmacy: _____ City, State: _____
 Your Height: _____ Your Weight: _____ **Allergies: please list medication and reaction** _____

Review of Systems:

Do you currently have problems in the following areas?	Yes	No	If yes, explain
Eyes (poor vision, eye pain, tearing, redness, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye injury: Previously <input type="checkbox"/> Currently <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever, heat stroke, weight loss, weight gain, unusually tired	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat (hearing loss, stuffy nose, ear ache, cough)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (congestion, wheezing, short of breath)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (upset stomach, hernia, constipation, ulcers)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary (painful, difficult, or frequent urination, impotence)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Females (Are you pregnant? Nursing?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal (joint pain, stiffness, swelling, arthritis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin (change in mole, growths, rash, warts, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological (numbness, headache, seizures, paralysis, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric (anxiety, depression, insomnia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/Lymph (history of clots, bleed easy, anemia, high cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/Immunologic (sneezing, itching, hives, lupus, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (high blood pressure, racing pulse)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine (diabetes, thyroid, lymph disorders, pituitary)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you or your family (mother, father, grandparents, sibling) had any of the following?

	Self	Family		Self	Family		Self	Family
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>

List any surgeries you have had. (Include minor surgeries)

Have you ever had eye surgery include laser procedures? Yes No If yes please list

Do you drink alcohol? Yes No If yes, how much? _____

Do you smoke? Yes No If yes how much? _____ How many years? _____

Marital Status: Married Single Divorced Widow

Signature Patient/Guardian/POA: _____ Date: _____

Relationship: _____

Doctor Signatures 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Tech Signatures 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____


Wabash Valley Eye Center
Patient Lifestyle Questionnaire 8/2010

We appreciate your time with this. Our doctors want to better understand your eyes. Please ...check, circle, and fill in the blanks & we thank you!

Occupation: _____

Do you drive for a living? Yes require CDL No

How many hours per day would you guess you are on the computer?
 0 2-4 more than 5

What hobbies do you enjoy?

Water sports / boating Hunting Reading Bicycling
 Travel Fishing Walking Golfing

Other: _____

Do you wear: (please circle) Contact Lenses Glasses: with / without bifocals Reading glasses only don't wear or don't have glasses / contacts

Do you have more than one pair of glasses? Yes No

Do you wear prescription sun-glasses? Yes No

Which statement best describes your eyes : choose as many as are appropriate for you and please report how long you have noticed this

Sensitive to light while in a grocery or department store
for _____ days/ months / years other: _____

Glare from car lights and or sunlight hinders ability to drive it difficult to drive -
for _____ days/months / years other: _____

Just do not see as well as I would like to for _____ days / months / years
other: _____

Trouble watching TV, reading,

Irritated, red, watery for _____ days/months / years other: _____

Straining to see when I _____ for _____ days/ months / years
other: _____

Not happy with my glasses for _____ days/ months / years other: _____
Other: _____

Anything else you would like to share with us? _____

Name : _____ - Date: _____

**Wabash Valley Eye Surgery Center
Wabash Valley Eye Center
Wabash Valley Skin Care
Ocular Management**

We will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our web site, and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature of Patient	Date
Signature of Patient's Legal Guardian or Representative	Relationship to Patient

**Notice to Wabash Valley Eye Center Patients
Regarding Dilation of Your Eyes**

We would like to inform our patients that it may be necessary during the course of your exam to **dilate your eyes with drops**. In some people, the dilating drops cause blurred vision, light sensitivity, and inability to read or drive safely. These problems go away as the effects of the drops wear off. You should be careful walking, going up and down stairs, and driving if someone is not available to accompany you home.

It is for this reason that we recommend someone come with you at the time of your exam as a driver. Also, for your comfort, you may obtain dark glasses or inserts for your glasses at the reception desk.

I certify that I have read and understand the statement regarding dilation and wish to proceed with the eye exam.

Signature of Patient	Date
Parent or Guardian	



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Chart #** _____

Date of Birth: _____

Information to be Used or Disclosed:

- All Protected Health Information
- Just the last 2 years of Protected Health Information
- Pertinent to stated condition: _____
- Other – as listed: _____

Persons to Whom Information May be Disclosed:

To: _____ (Spouse, Physician, other)

_____ (Address)

_____ (City, State, ZIP)

From: **Wabash Valley Eye Center**
2020 Clearview Dr
Vincennes, IN 47591-0924

Right to Terminate or Revoke Authorization

This authorization will remain valid unless revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to Wabash Valley Eye Center. You should contact Deedra Funk and/or Angie Brown, Privacy/Compliance Officer, to terminate this authorization.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature of Patient

Signature of Patient Representative

Relationship of Patient Representative to the Patient

PATIENT IDENTIFICATION- Please Print									
Patient's First Name				Middle			Last		
Age		Date of Birth			Address				Apt. #
City				State		Zip		Social Security	
Home Phone			Business Phone				Marital Status		
Employer's Name					Address				
Alternate Contact Person					Phone (Different # than home phone)				
Referred By				Email Address					
FINANCIAL RESPONSIBILITY									
Last Name				First			Middle		Date of Birth
Address			City			State		Zip Code	
Home Phone			Business Phone				Employer		
VISA Card #		Expiration		MASTERCARD #		Expiration		Signature	
INSURANCE-PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST									
Insurance Company						Policy Holder			
Policy #		Group #			Effective Date		Policy Holder's Date of Birth		
Insurance Company						Policy Holder			
Policy #		Group #			Effective Date		Policy Holder's Date of Birth		

I consent to treatment necessary for the care of the above named patient.

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.

I allow fax transmittal of my medical records, if necessary.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. Refrctions are not typically covered by insurance or government programs and are the patient's responsibility.

I understand that proof of insurance must be presented at the time of service. I will provide valid insurance information on the day of service. If no insurance information is provided, I understand that payment is due the day of service, and no insurance billing will be provided at a later date.

I authorize and request that insurance payments be made directly to Wabash Valley Eye Center should they elect to receive such payment.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. In the event, the charges incurred are not paid in full when due and collection action is instituted, whether by a collection agency or attorney, or both, I agree to be responsible for and pay, in addition to the charges for services and treatment received, all costs associated with such collection activity. These costs include, but are not limited to, reasonable collection agency fees, attorney fees, court cost and/or any other expenses incurred in its collection.

Date

Signature