Medical History Questionnaire

CLEAR VISION EYE CARE CENTER / Dr. Derrick Skaggs and Associates, P.C.

Last Name:______________________ First:______________________ Middle:__________ Today's Date: ______________

Address:______________________________ City:______________________ State:_______ Zip: ______________

Home Phone: (___)______________ Work: (___)______________ Cell: (___)______________ E-Mail: ______________

Sex: ☐ M ☐ F Date of Birth:_____/_____/________ Age:________ Social Security:________/______/ ______________

Employer:__________________ Occupation:____________________ Address: ______________________________

Person Responsible for Patient:____________________ Relationship:______________ Phone:(_____) ______________

In case of emergency, contact: (not living in your household)

Name:______________________________________ Relationship: ______________________________

Home Phone: (_____)______________ Work: (_____)______________ Cell: (_____) ______________

Medical History

Name of Medical Doctor:______________________________ Dr.'s Phone Number: (_____) ______________

Last Medical Exam: _________/_________/___________ Last Eye Exam: _________/_________/___________

Do you have any allergies to medications? ☐ Yes ☐ No If yes, explain: ______________________________

____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and remedies): ______________

____

____

____

List all major injuries, surgeries and/or hospitalizations you have had: ______________________________

____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infection, or eye injury: ______________________________

____

Are you pregnant and/or nursing? ☐ Yes ☐ No If yes, how long? ______________________________

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? ______________________

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? ______________________

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ Yes ☐ No

Medical History Questionnaire

Dr. Derrick Skaggs and Associates, P.C.

History

Please note any history for you or your family (parents, grandparents, siblings, children, living or deceased) for the following conditions:

Disease/Condition	You	Relative	Relationship to You	Disease/Condition	You	Relative	Relationship to You
Blindness	❑	❑	________	Lupus	❑	❑	________
Cataracts	❑	❑	________	Thyroid Disease	❑	❑	________
Crossed Eyes	❑	❑	________	Amblyopia (Lazy Eye)	❑	❑	________
Glaucoma	❑	❑	________	Retinal Disorder	❑	❑	________
Macular Degeneration	❑	❑	________	Iritis	❑	❑	________
Retinal Detachment/Disease	❑	❑	________	Eye Surgery	❑	❑	________
Arthritis	❑	❑	________	Asthma	❑	❑	________
Cancer	❑	❑	________	Allergies	❑	❑	________
Diabetes	❑	❑	________	Multiple Sclerosis	❑	❑	________
Heart Disease	❑	❑	________	Kidney Disease	❑	❑	________
High Blood Pressure	❑	❑	________	Other:________	❑	❑	________

Insurance

• Optical Insurance Company : ________________

Name of Insured: ________________ Relationship: ________________

Insured's ID#: ________________ Policy or Group#: ________________

Optical Insurance Company's Phone Numbers: ____________ or ____________

• Major Medical Insurance Company : ________________

Name of Insured: ________________ Relationship: ________________

Insured's ID#: ________________ Policy or Group#: ________________

Major Medical Insurance Company's Phone Numbers: ____________ or ____________

• Medicare ID#: ________________ Secondary: ________________

I hereby authorize Dr. Skaggs and Associates, P.C. to release any information concerning my care to my insurance company and other physicians associated with my care. I hereby authorize payment directly to Dr. Skaggs and Associates, P.C., benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by my insurance. Further, if my insurance is different from the above named companies and/or Dr. Skaggs and Associates, P.C. is unable to recover payment, I will be responsible for the full amount. I certify that the above information is true and correct to the best of my knowledge.

Patient Signature ________________________ Date ____________

Are you interested in what's available for you in contact lenses? ❑ Yes ❑ No

Have you ever considered Laser Vision Correction? ❑ Yes ❑ No

For medically necessary reasons, I understand that the doctor may need to dilate, run a visual field, or take retinal photos of my eye. I understand that there will be additional charges for these services. There will also be an additional charge for a contact lens exam.

I will be paying today by Cash:__________Check:__________Credit Card__________.

PAYMENT IS DUE WHEN SERVICES ARE RENDERED AND ARE NONREFUNDABLE.

I have read all the information on both sides of this sheet and completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Patient's Signature________________________________Date ____________