

Family Eye Care

860-584-5528

Dr. Helen J. Zervas, Optometrist

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: ____ / ____ / ____

Address: _____ Phone: _____

Work Phone: _____

Birth Date: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Last Eye Exam: ____ / ____ / ____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Last Medical Exam: ____ / ____ / ____

Medical History

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home 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 infections or eye injury: _____

Are you pregnant and/or nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no

Family History

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

* Please turn this form over and complete side two *

Social History

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

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

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If yes, please describe:

Do you use tobacco products? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you use illegal drugs? no yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL					EARS, NOSE, MOUTH, THROAT		
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL					Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
EYES					RESPIRATORY		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		VASCULAR / CARDIOVASCULAR		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		GASTROINTESTINAL		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		GENITOURINARY		
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		BONES / JOINTS / MUSCLES		
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		LYMPHATIC / HEMATOLOGIC		
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE					Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>
					PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

Doctor's Signature

Date

Family Eye Care

860-584-5528

Dr. Helen J. Zervas, Optometrist

PATIENT & INSURANCE INFORMATION

NAME: _____

DATE OF BIRTH: ____ / ____ / ____ AGE _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

EMERGENCY PHONE _____

OCCUPATION _____

SPOUSE'S NAME _____

EMERGENCY PHONE _____

REFERRED BY _____

PRIMARY INSURANCE PLAN: _____

GROUP# _____ POLICY # _____

SECONDARY INSURANCE PLAN: _____

GROUP # _____ POLICY # _____

PAYMENT POLICY

PROFESSIONAL FEES ARE DUE AT THE TIME THE SERVICES ARE RENDERED. A DEPOSIT OF HALF OF THE TOTAL COST OF PRESCRIPTION EYEGLASSES OR CONTACT LENSES IS REQUIRED IN ADDITION TO THE EXAMINATION FEES. THE BALANCE OF YOUR EYEGLASSES AND / OR CONTACT LENSES IS DUE WHEN THEY ARE DISPENSED. THERE WILL BE A \$20.00 RETURN CHECK FEE. PATIENTS WILL BE BILLED BY THIS OFFICE ON A MONTHLY BASIS EVEN IF EYEGLASSES OR CONTACT LENSES HAVE NOT BEEN DISPENSED OR IF AN INSURANCE CLAIM HAS BEEN FILED.

LIFETIME AUTHORIZATION / SIGNATURE ON FILE

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS (INCLUDING MEDICARE) FOR ANY SERVICES FURNISHED TO ME, BE MADE ON MY BEHALF TO DR. HELEN J. ZERVAS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

METHOD OF PAYMENT: ____ CASH ____ CHECK ____ MASTERCARD ____ VISA

SIGNATURE _____ DATE: ____ / ____ / ____

Acknowledgement of Receipt of Notice of Privacy Practices

Family Eye Care, Dr. Helen J. Zervas, O.D.

780 King Street, Bristol, CT 06010

(860) 584-5528

Fax: (860) 583-4949

E-Mail: drzervas@familyeyecaredr.com

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

*Signing this document signifies that you have
received a copy of our Notice of Privacy Practices.*

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Family Eye Care, Dr. Helen J. Zervas, O.D.

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient

Print Name

Source of Authority: _____