Parkwood Eye Center, P.A.
Medical History Questionnaire

Mr. Mrs. Miss
Ms. Dr. _____ Date of Birth: _____
(circle one) First Middle Last

Referred By: _____ Primary Care Doctor: _____

Allergies (please list): _____

Current Eye Medications (please list): _____

Eye History:

Have you ever had any of the following eye problems? (Please check Yes or No for each)

	Yes	No
Cataracts		
Retinal Detachment		
Glaucoma		
Macular Degeneration		
Lazy/Misaligned Eyes		
Diabetic Eye Disease		
Retinitis Pigmentosa		
Dry Eyes		
Color Blindness		
Eye Trauma		
Iritis		

Medical History:

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Review of Systems:

Have you had any of the					
	No	Yes		No	Yes
Hearing loss			Environmental/food allergies		
Skin rash			Chest pain/irregular heartbeat		
Dizziness/headache			Fatigue/Fever/Night Sweats		
Blood in urine			Increased thirst/appetite		
Emotional changes			Constipation/diarrhea/vomiting		
Cough and wheezing			Bruising/easy bleeding		
			Joint pain/muscle weakness		
Please explain any "Yes" responses:					
Have you had a vaccine for					

Social History:

Marital Status:	Single	Married	_ Divorced Widowed
Occupation:		Employer:	
Hobbies:			
Do you consume alcohol	____ Yes ___No	How much?	
Do you smoke	____ Yes ___No	How much?	

Family History:

Has anyone in your family					
	No	Yes		No	Yes
Glaucoma			Blindness		
Retinitis pigmentosa			Diabetes		
Macular degeneration			Heart disease		
Retinal detachment			High blood pressure		
Corneal Disease			Blood disorders		
Misaligned eyes					

Please sign and date:

Signature of Patient or Guardian _____ Date _____

Parkwood Eye Center, P.A.
Authorization To Release Protected Health Information (PHI)
Authorization To Obtain and Use Prescription History
Acknowledgement of Receipt of Privacy Practices

. Unless you notify us that you object, you agree that we may disclose to a family member or relative your health information relevant to that person's involvement in your care or payment for your care. In addition, we may disclose your PHI to the individuals identified below. I authorize Parkwood Eye Center, P.A. to release any personal information relating to my health care.

To: _____Relationship To Patient:_____

To: _____Relationship To Patient: _____

To: _____Relationship To Patient: _____

To: _____Relationship To Patient:_____

. I understand I have the right to restrict information that may be released and this restriction must be in writing.

____No Restrictions

____With restrictions (list): _____

. I agree that Parkwood Eye Center, P.A. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Printed Name Date

Signature

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature:_____ Date: _____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

____ An emergency existed & a signature was not possible at the time.
____ The individual refused to sign.
____ A copy was mailed with a request for a signature by return mail.
____ Unable to communicate with the patient for the following reason:
_____
___ Other: _____