Medical History Questionnaire

Bridgemill Eyecare 1409 Sixes Road, Canton, GA 30114

Name:________________________________ Married ☐ Single ☐ Today's Date: _______ / ______ / ______
Address:____ Phone: ___________________________
City:________________________ State:________Zip Code:_____________ Cell Phone: ______________________
Home Email Address:_________________________ Preferred methold of contact: ________________________
Birth Date: _____ / _____ / _____ Social Security #:_______ / _____ / ______ Last Eye Exam:______ / _______ / ______
Occupation:____ Hobbies:_______________________________
Name of Medical Doctor:______________________Dr.'s Phone: ________________Pharmacy:___________________
How did you hear about us?______________________________________ Last Medical Exam: _____ / _____ / _____
Primary Insured Name:________________________ DOB____________________SS#__________________________
Getting to know you...List any persons residing with you____

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 mediation 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 Have you had LASIK/PRK surgery? ☐ no ☐ yes

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

Do you wear contact lenses? ☐ no ☐ yes Type of contact lenses: ☐ Gas Perm ☐ Soft

Are you currently under the care of HOSPICE? ☐ no ☐ yes EYE COLOR: ______________

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

DISEASES/CONDITIONS	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	________________________
Cataract	☐	☐	☐	________________________
Crossed Eyes	☐	☐	☐	________________________
Glaucoma	☐	☐	☐	________________________
Macular Degeneration	☐	☐	☐	________________________
Retinal Detachment/Disease	☐	☐	☐	________________________
Cancer	☐	☐	☐	________________________
Diabetes	☐	☐	☐	________________________
Heart Disease	☐	☐	☐	________________________
High Blood Pressure	☐	☐	☐	________________________
Kidney Disease	☐	☐	☐	________________________
Lupus	☐	☐	☐	________________________
Thyroid Disease	☐	☐	☐	________________________
Other ____________________	☐	☐	☐	________________________

***We make every effort at the time of service to determine your complete benefit information from your insurance carrier. Please be advised the information provided to us by your carrier is not a guarantee of coverage and will not be determined until the final claim is processed by your carrier. We provide services that are necessary based on your medical condition and the care required. We bill for those services using national standards and billing rules. Your insurance company's rules will determine how the claim is paid. If after processing the claim, the insurance carrier determines that benefits are a "non-covered" benefit or subject to deductible, the patient will be responsible for the remaining balance and notified with a copy of the Explanation of Benefits and billed at that time.**

**** Please turn this form over and complete side*** ___________ **Patient Initials**