METZGER Eye Care

N P

PATIENT HISTORY QUESTIONNAIRE

(completion required at each patient appointment)

Welcome to our office! **Date**____________________

Reason for Today's Visit:
__Eye Examination **__Medical Problem** **__Contact Lens Examination** **__Other**__________

Last Name__________________________First Name__________________________MI_________Male Female

Home Address______________________City___________________State________Zip______________________
Age________Birth Date_______________SSN___________________Home Phone_________________________
Employer/School______________________Occupation/Grade (if student)___________Cell Phone_______________
Email________________________Marital Status: __Single __Married __Divorced __Widowed __Legally Separated

Name of Parent, Legal Guardian or Spouse____
Name of family members whom we have provided care______________Referred By___________________

Vision Insurance Company________________ID#____
Subscriber name________________Relationship to patient___________Subscriber Birth Date______________

Medical Insurance Company_______________ID#____
Subscriber name________________Relationship to patient___________Subscriber Birth Date______________

Race:
__American Indian or Alaskan Native __Asian __Black or African American
__Native Hawaiian or other Pacific Islander __White or Caucasian

Ethnicity:
__Hispanic or Latino
__Not Hispanic or Latino

Preferred Language:___________________

Eye History: Do you have or have you had any of the following problems?

Y N Cataracts	Y N Double Vision	Y N Dry Eye	Y N Eye Injury
Y N Eye Surgery	Y N Flashes	Y N Floaters	Y N Glare
Y N Glaucoma	Y N Itchy/Burning	Y N Lazy/Crossed Eye	
Y N Macular Degeneration		Y N Retinal Detachment	

Last eye care provider:_____________________________Date of last exam_____________________________
Currently having eye or vision problems? Y N If yes, please explain__________________________
Hobbies/Activities/Sports____
Do you work at a computer/e-reader/video games/smart phone, etc? Y N How many hours per day?_________
______

Do you wear glasses? Y N How old are your glasses?_________When do you wear your glasses?______________
Any problems with your glasses?__________________________How long have you been wearing glasses?________

Have you ever worn/Do you wear contact lenses? Y N If so, what brand?___________________________
Fit by whom?____Hours per day you wear contacts?______________
How often do you replace them?_____________________________Which solutions do you use?________________

If you are interested in contact lens wear, please read the following information regarding contact lenses.

Metzger Eye Care prescribes quality contact lenses to improve your vision and your lifestyle. Contact lenses are FDA regulated medical devices that can cause discomfort, infections and even permanent vision loss if not cared for properly. New and existing contact lens wearers require additional time and testing during an eye examination to minimize the risk of serious eye problems. This additional testing is only done for contact lens wearers, not for patients who do not wear contact lenses. For this reason, there are additional contact lens evaluation and services fees for new and existing contact lens wearers. Your contact lens evaluation and services fee includes:

1. **Specific curvature measurements of the cornea.**
2. **Evaluation of current and new lenses to ensure optimal fit, vision and comfort.**
3. **Medical assessment of the cornea, tear film and conjunctiva as they relate to contact lens wear.**
4. **Instructions regarding safe contact lens wear, care and proper cleaning and solutions.**
5. **Contact lens follow-up care for 1 year.**

If you have any questions, please do not hesitate to speak with your doctor.

PATIENT HISTORY QUESTIONNAIRE (continued)

Name____________________________________

Medical History:

Height______________Weight_____________List any medications you are currently taking. (Prescription or over the counter):

____

____

Are you allergic to any medications: Y N Please list:____

Primary Care Physician's Name:________________________Location:_____________________________

Preferred Pharmacy:___________________________________Location:________________ Phone:_______________

Do you have or have you ever had any of the following problems:

Y N Alcohol Use (Frequent)
Y N Allergies: Type_________________
Y N Blood/Lymph Disorders
Y N Cancer: Type___________________
Y N Developmental Delay
Y N Diabetes
Y N Ear, Nose, Throat Disease
Y N Exposure or Infected with Hepatitis
Y N Exposure or Infected with HIV
Y N Genitourinary Problems
Y N Thyroid Problems

Y N Headaches (Frequent)
Y N Heart Problems
Y N High Blood Pressure
Y N High Cholesterol
Y N Mental Health Issues
Y N Neurological Disorders
Y N Pregnant/Nursing (Currently) Months____________
Y N Respiratory Problems: Type___________________
Y N Sexually Transmitted Disease
Y N Skin/Muscular Disorders
Y N Stomach/Intestinal Problems
Y N Substance Abuse History

Other Condition/Illness:____

Smoking History: __Current Smoker __Former Smoker __Never Smoked

Family History: (Mother, Father, Grandparents, Siblings)

__Blindness __Cataracts __Glaucoma __Lazy/Crossed Eye __Macular Degeneration __Retinal Detachment
__Diabetes Other Eye Disease or Condition:____

If patient is 18 or under, please complete:

Do you have any concerns with your child's school performance?____________________________________

PAYMENT INFORMATION:

At Metzger Eye Care, we make every effort to serve you efficiently, please note our following payment policies:

For your convenience we accept cash, check, credit cards (American Express, Visa, MasterCard, Discover).
Payment for all services and products is the responsibility of the patient.
I agree to pay all co-pays, deductibles, co-insurances and non-covered services as determined by my insurance company.
I understand there is a returned check fee applied to every returned check.
I agree to pay an additional collection fee for all accounts not paid in the time stated on the final monthly statement.
I authorize release of medical information concerning my illness and treatment by Metzger Eye Care to my insurance company.
I also authorize the release of my personal medical information to any doctor whom I may be referred.
I understand verification of eligibility is not a guarantee of payment as stated by my insurance company.

PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE

We will file all insurance forms if Metzger Eye Care is a participating provider for your plan.

____ ______________________________

Signature of patient or legal guardian Today's Date