

Medical History Questionnaire

Furey Family Eye Care 250 E Crossville Road, Roswell, GA 30075

Name: _____ Married Single Today's Date: ____/____/____
 Address: _____ Phone: _____
 City: _____ State: _____ Zip Code: _____ Work Phone: _____
 Home Email Address: _____ Work Email Address: _____
 Birth Date: ____/____/____ Social Security #: ____/____/____ Last Eye Exam: ____/____/____
 Occupation: _____ Hobbies: _____
 Name of Medical Doctor: _____ Dr.'s Phone: _____
 How did you hear about us? _____ Last Medical Exam: ____/____/____
 Primary Insureds 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 medication 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 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? no yes

Family History

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

DISEASES/CONDITIONS	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"/>	_____

***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 two * _____ Patient Initials