Jordan Brooks O.D.

# PATIENT HISTORY QUESTIONNAIRE

**Patient Name:** ____________________________________ **Date**:______________________________

**Circle Yes or No** if you have or had any of the following medical conditions and **describe where indicated…**

High Blood Pressure Yes/No Nervous ___________________________ Gastrointestinal ______________________
High Cholesterol Yes/No Mental _____________________________ Urinary ____________________________
Headaches Yes/No Ear/Nose/Throat _____________________ Endocrine __________________________
Asthma Yes/No Respiratory ________________________ Blood/Lymph ________________________
Cardiovascular _________________ Muscle/Bones ________________ Allergenic/Immunologic ______________
Integumentary (skin) ____________________Diabetes Yes/No Type__________Date of Diagnosis____________

Other Health Problems_______________________________________________________________
Allergies to Medication? Yes/No Which? ______________________________________________
_______________________________________________Reactions__________________________
Current Medication(s) Check if none □_________________________________________________
___________________________________________________________________________
___________________________________________________________________________
Current Eye Drops Check if none □____________________________________________________
Have you had any operations? Yes/No Kind? ___________________________________________
____________________________________________________When_____________________
Are you pregnant? Yes/No Breast feeding? Yes/No
Preferred Pharmacy ______________________ Name of Primary Care Physician______________________

**Social History**

Tobacco Yes/No Alcohol Yes/No Other substances_______________________________

**Family History**

Diabetes Yes/No Relation _____________ Macular Degeneration Yes/No Relation_______________
Glaucoma Yes/No Relation______________ Retinal Detachment Yes/No Relation ______________
Cataracts Yes/No Relation _____________
Other serious eye disease Yes/No Name of condition_______________ Relation________________

**Personal Eye Information**

Do you have any eye conditions or problems? Yes/No What kind?__________________________________
Have you had any eye operations? Yes/No Type___________________________________________
Have you had an eye injury? Yes/No Type___________________________________________

| | | | |
|---|---|---|---|
| **Glaucoma?** | **Yes/No** | **Dry Eyes?** | **Yes/No** |
| **Macular Degeneration?** | **Yes/No** | **Blurred Vision?** | **Yes/No** |
| **Retinal Detachment?** | **Yes/No** | **Cataracts?** | **Yes/No** |

Date of last eye examination _________________________
Have you seen Dr. Brooks in another office? Yes/No Where?______________________________________
Do you wear glasses? Yes/No Contact Lenses? Yes/No Type_________________________________

# Brooks Eye Care

## PATIENT INFORMATION

Last Name________________________________First Name________________________MI________

Mailing Address_________________________________________________ Apartment #____________

City_______________________________________________State__________ Zip_________________

Secondary/Northern Address_____________________________________________________________

City_______________________________________________State__________Zip_________________

Date of Birth_______________Employer_________________________Occupation_________________

Cell Phone (___)_________________ Home (___)_________________ Work (___)_________________

SSN ______________________________ E-Mail____________________________________________

Emergency Contact Name__________________________________Phone Number (___)_____________

How did you hear about Brooks Eye Care? ________________________________________________

## INSURANCE INFORMATION

Please initial:

________ I certify that I (or my dependent) have insurance and/or Medicare coverage, and assign direct payment to Brooks Eye Care for service and material benefits. I authorize the use of this signature on all insurance submissions.

________ I understand that I am financially responsible for all co-pays, deductibles, materials and services not covered by my insurance and/or Medicare. I authorize Brooks Eye Care to release any information necessary to secure payment of benefits.

________ I have read and understand my HIPPA Rights and Responsibilities, or have been offered a copy to take with me. We keep a copy at the front desk for you to read.

________ For patients with Medicare or other medical insurance coverage - I understand that Medicare and most medical insurance companies do not cover the refraction (test used to determine the glasses prescription) and that I am responsible for the $50 refraction fee. If you have separate vision insurance that will be billed for a visit, a refraction is covered. If you have medical and vision insurance and your chief complaint is medical in nature, your medical insurance will be billed for the exam and you will be charged for a refraction if preformed.

________________________________ ________________

Signature Date