Valley Vision Associates

Robert Davis, OD Daniel Hanson, MD Erick Johnson, OD Emily M. Korszen, OD Abel Li, MD Scott Oltman, OD

PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Patient Name: _____ **Date**: _____

Primary Care Physician: _____ **Pharmacy**: _____

Do you wear Glasses? **YES** **NO** **Do you wear Contact Lenses?** **YES** **NO**

Medical History (Check all that apply or circle none): **NONE**

- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Diabetes: Type _____
- ❒ Arthritis
- ❒ Hepatitis
- ❒ Thyroid Disease
- ❒ HIV Positive
- ❒ Cancer
- ❒ Heart Problems
- ❒ Glaucoma
- ❒ Cataract
- ❒ Macular Degeneration
- ❒ Retinal Detachment
- ❒ Strabismus (crossed eyes)
- ❒ Eye Injury
- ❒ Eye Surgery:_____

Medications:

❒ None

Medication Allergies:

❒ No Known Drug Allergies

Previous Hospitalization or Surgery: _____

Review of Systems: *Do you currently have any of the following problems:*	**Yes**	**No**	**If YES, please explain**	For Doctors & Techs: Initials & Date	Initials & Date
Eyes (e.g., pain, tearing, redness, itching, sudden loss of vision)	❒	❒			
Constitutional/Symptom (e.g., fever, weight loss/gain, fatigue)	❒	❒			
ENT/Mouth problems (e.g., hearing loss, sinus problems, cough)	❒	❒			
Cardiovascular (e.g., chest pain, irregular heart beat, pacemaker)	❒	❒			
Respiratory problems (e.g., shortness of breath, wheezing)	❒	❒			
Hematologic/Lymphatic (e.g., bleeding, anemia)	❒	❒			
Allergies (e.g., hay fever, hives)	❒	❒			
Gastrointestinal problems (e.g., abdominal pain, diarrhea)	❒	❒			
Urinary problems (e.g., pain or discomfort, blood in urine)	❒	❒			
Skin problems (e.g., rashes, excessive dryness, rosacea)	❒	❒			
Musculoskeletal problems (e.g., muscle aches, joint pain)	❒	❒			
Neurologic problems (e.g., numbness, weakness, headaches)	❒	❒			
Endocrine problems (e.g., diabetes, thyroid)	❒	❒			
Psychiatric problems (e.g., depression, anxiety)	❒	❒			
Alerts: *Do you have or are you using any of the following:*					
MRSA	❒	❒			
Pregnancy	❒	❒			
Flomax medication	❒	❒			
Allergy to adhesive	❒	❒			
Allergy to lidocaine	❒	❒			
Allergy to iodine	❒	❒			
Premedication prior to procedures	❒	❒			

Family History:

- ❒ Blindness
- ❒ Retinal Detachment
- ❒ Crossed/Lazy Eye
- ❒ Cataract
- ❒ Glaucoma
- ❒ Macular Degeneration

Social History:

Do you use….? Tobacco ❒ Yes ❒ No Alcohol ❒ Occasionally ❒ Rarely ❒ Never

Payment and Account Information:

**If you have both types of insurance (Vision and Medical) plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.

Please initial:

_____ I certify that I (or my dependent) have insurance and/or Medicare coverage, and assign direct payment to Valley Vision Associates for services 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 Valley Vision Associates to release any information necessary to secure payment of benefits.

_____ I understand that I am financially responsible for all materials and services in the event no insurance is provided.

_____ I have read and understand my HIPAA Rights and Responsibilities
(we have a copy available at the Front Desk if needed)

_____ For patients with Medicare coverage- I understand that Medicare does not cover the refraction and that I am responsible for the $44 refraction fee; the test in which the prescription for glasses is written.

_____ I request that Valley Vision Associates, upon request, release all information related to my health care and general well-being, to the people listed below other than myself. You have my permission to talk to and release all medical records and information related to my health care to the person(s) listed below. This request is to be in effect until I submit a written request for a change.

Name	Relationship	Phone Number

_____ _____
Signature Date

_____
Print Name