HARTFORD EYE WELLNESS
419 Franklin Avenue, Suite 102 - Hartford, CT 06114

Patient Information and Medical History Questionnaire

Name: _____ Male □ Female □ Today's Date: _____

Address: _____ Phone: _____

City: _____ Work Phone: _____ Occupation: _____

Guardian (if applicable): _____ Email Address: _____

Birth Date: ___/___/___ Social Security# ___/___/___ Last Eye Exam: _____

Medical Health Insurance: _____ Policy/ID# _____

Vision Insurance: _____ Policy/ID# _____

Medical History:
Name of Medical Doctor: _____ Dr's Phone: _____ Last Medical Exam: _____

Do you have any allergies to medication? □ no □ yes If yes, explain: _____
List any medications you take (include oral contraceptives, aspirin, over the counter medication and home remedies):

_____

_____

_____

List all major injuries, surgeries and/or/ hospitalizations you have had: _____

_____

Circle 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. Explain/Details: _____

Are you pregnant and/or nursing? □ 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 contacts lenses: □ rigid □ soft □ extended wear □ other Are they comfortable? □ yes □ no

Family History
Please note the following history (parents, grandparents, siblings, children; living or deceased0 for the following conditions:

Disease/Condition	YES	Relationship to you	Disease/Condition	YES	Relationship to you
Blindness	□	_____	Cancer	□	_____
Cataract	□	_____	Diabetes	□	_____
Crossed Eyes	□	_____	Heart Disease	□	_____
Glaucoma	□	_____	High Blood Pressure	□	_____
Macular Degeneration	□	_____	Kidney Disease	□	_____
Retinal Detach Disease	□	_____	Lupus	□	_____
Arthritis	□	_____	Thyroid Disease	□	_____

Other _____ □ Yes _____

**Please turn this form over and complete side two

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

☐ Yes, I would prefer to discuss my social History information directly with my doctor. (check box)

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes If yes, please describe:

_____

Do you use tobacco products? ☐ no ☐ yes If yes, type/amount/how long:_____

Do you drink alcohol? ☐ no ☐ yes If yes, type/amount/how long:_____

Do you use illegal drugs? ☐ no ☐ yes If yes, type/amount/how long:_____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Have you been diagnosed with sleep apnea? ☐ no ☐ yes

Have you ever felt faint or actually fainted during any type of professional services provided to you? ☐ no ☐ yes

Review of Systems: Do you currently, or have you ever had any problems in the following areas:

	YES		Yes		Yes
Constitutional		**Eyes**		**Endocrine**	
Fever, weight loss/ gain	☐	Tired Eyes/eye strain	☐	Thyroid/Other Glands	☐
Neurological	☐	Loss of Vision	☐	**Psychiatric**	☐
Headaches	☐	Blurred Vision	☐	**Lymphatic/Hematologic**	☐
Migraines	☐	Distorted Vision/Halos	☐	Anemia	
Seizures	☐	Loss of Side Vision	☐	**Integumentary (skin)**	☐
Stroke	☐				
Bleeding Problems	☐	Double Vision	☐	**Allergic/Immunologic**	☐
Numbness	☐	Dryness	☐		
Tingling	☐	Mucous Discharge	☐	**Gastrointestinal**	
Paralysis	☐	Redness	☐	Diarrhea	☐
Weakness	☐	Sandy or Gritty	☐	Constipation	☐
Ears, Nose, Mouth, Throat		Itching	☐	**Genitourinary**	☐
Allergies	☐	Burning	☐	Genitals/Kidney/Bladder	☐
Sinus Congestion	☐	Foreign Body Sensation	☐	**Bones/Joints/Muscles**	☐
Runny Nose	☐	Excess Tearing/Watering	☐	Rheumatoid Arthritis	☐
Post Nasal Drip	☐	Glare/Light Sensitivity	☐	Muscle Pain	☐
Chronic Cough	☐	Eye Pain or Soreness	☐	Joint Pain	☐
Dry throat/mouth	☐	Chronic Infection of			
Respiratory		eye or lid	☐		
Asthma	☐	Flashes/Floaters in Vision	☐		
Chronic Bronchitis	☐	Decreased vision in		**Vascular/Cardiovascular**	☐
Emphysema	☐	dim light	☐	Diabetes	☐
				High Blood Pressure	☐
				Vascular Disease	☐
				Low Blood Pressure	☐

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Tolland Eye Care LLC for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid services and its agents and information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the SMC-1500 claim form or electronically submitted claim, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. **I understand that all benefits quoted to me are not a guarantee of payment by my insurance company & that final determination can only be made when the claim is processed.**

_____ _____

Patient Signature *Date*