ANNAPOLIS VISION CENTER
HEALTH HISTORY QUESTIONNAIRE

APPOINTMENT DATE
TECHNICIAN

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Primary Care Doctor:	**Date of last physical exam:**
Other Doctor:	**Specialty:**
Other Doctor:	**Specialty:**
Your Preferred Pharmacy:	**Occupation:**

REASON FOR VISIT ☐ **ROUTINE EYE EXAM** ☐ **MEDICAL OCULAR COMPLAINT** ☐ **DIAGNOSTIC TESTING**

DO YOU CURRENTLY WEAR GLASSES: ☐ **NO** ☐ **YES** *FOR* ☐ **FULL TIME** ☐ **DRIVING** ☐ **DESKTOP COMPUTER** ☐ **PHONE/BOOKS**

GLASSES COULD BE IMPROVED FOR: ☐ **DRIVING** ☐ **DESKTOP COMPUTER** ☐ **PHONE/BOOKS** ☐ **NO VISION ISSUES**

DO YOU CURRENTLY WEAR CONTACTS ☐ **NO** ☐ **YES** *FOR* ☐ **ALL DAY WEAR** ☐ **FUN/SPORTY** ☐ **SLEEP IN THEM**

CONTACTS COULD BE IMPROVED FOR: ☐ **DRIVING** ☐ **DESKTOP COMPUTER** ☐ **PHONE/BOOKS** ☐ **COMFORT ISSUES** ☐ **NO ISSUES**

MY CONTACTS ARE: ☐ **1 DAY THROW AWAY** ☐ **2 WEEK THROW AWAY** ☐ **MONTHLY THROW AWAY** ☐ **OTHER:** ________________

DISINFECTANT ☐ **OPTIFREE** ☐ **CLEAR CARE** ☐ **RENU** ☐ **BIOTRUE** ☐ **STORE BRAND:**_____________________

PERSONAL HEALTH HISTORY

Health Conditions	☐ Allergies ☐ Asthma	☐ Skin cancer ☐ Basal Cell ☐ Squamous Cell	☐ Herpes Simplex 1 (oral) ☐ Herpes Simplex 2 (genital)	☐ Herpes Zoster
	☐ Hypertension	☐ Thyroid Disease ☐Overactive ☐Underactive	☐ Depression ☐ Anxiety	☐ ADD/ADHD
	☐ High Cholesterol	☐ Eczema ☐ Acne Rosacea ☐ Dermatitis	☐ Migraines	☐ Autoimmune Disease: ______________________________
	☐ Dry Eyes	☐ Retinal Detachment ☐ Vitreous Detachment	☐ Lazy Eye	☐ Blepharitis/Lid Disease
	☐ Ocular Allergies	☐ Glaucoma ☐ Cataracts	☐ Double Vision	☐ Other:_____________________

☐ Diabetes ☐ Type 1 ☐ Type 2 Year Diagnosed ________ Last a1C ________ Date _________ Glucose __________ Date:__________

List any other medical or eye problems that other doctors have diagnosed ☐ **NONE**

Surgeries (All types including eye surgery) ☐ **NONE**

Year	Reason	

Other hospitalizations		☐ **NONE**
Year	Reason	

List ALL your prescribed drugs, over-the-counter drugs, including vitamins and supplements		☐ **NONE**
Name the Drug	Strength	Frequency Taken

Allergies to medications ☐ **NO SYSTEMIC DRUG ALLERGIES**	☐ **NO OCULAR DRUG ALLERGIES**
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Do you drink alcohol?	☐ Yes	☐ No
Socially on occasion ________ 1-2/day __________ Alcohol dependent ___________		
Do you use tobacco? ☐ Never ☐ Current ☐ Former: Year Quit: __________		
☐ Cigarettes __________ pks./day ☐ # of years		
Do you have a history of sexually transmitted disease?	☐ Yes	☐ No
Do you currently use narcotics?	☐ Yes	☐ No
Are you HIV positive	☐ Yes	☐ No
Have you ever had a blood transfusion?	☐ Yes	☐ No
Have you ever suffered a concussion?	☐ Yes	☐ No

Name:________________________________ DOB: ___________

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

FAMILY EYE HEALTH

Has anyone in your family ever been diagnosed with macular degeneration?	☐ Yes	☐ No
Has anyone in your family ever been diagnosed with glaucoma?	☐ Yes	☐ No
Has anyone in your family been born with a lazy eye or blindness?	☐ Yes	☐ No
Other:		

Assignment of Benefits

I request the payment of authorized benefits be made on my behalf to Annapolis Vision Center for any and all services and/or products received by me. I authorize any holder of medical information about me to release to Annapolis Vision Center and its agents any information needed to determine these benefits payable for related services.

I certify that the information I have reported regarding myself and my insurance coverage is correct, and this assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Annapolis Vision Center will adhere to the eligibility and benefits under guidelines provided by your reported insurance company. Please realize that we cannot guarantee payment of claims.

I understand that I am financially responsible for all charges, whether or not paid by insurance. Annapolis Vision Center will file my insurance claim with the information provided by me, however the responsibility for the charges remains with me and must be paid by the due date, regardless of insurance. I hereby agree to this provision. I understand that this document will require updating on an annual basis or sooner if my insurance carrier changes.

Office Policy

Is it customary to pay for all services as they are rendered.

Please be prepared to pay all co-payments today with cash, check or charge.

The is a $25 billing fee if your exam co-payment is not paid before the close of business today.

Professional fees are non-refundable. Spectacles and contact lenses are considered custom orders that have been prescribed by the doctor and are not transferable from one individual to another. Annapolis Vision Center will extend refunds and credits for those items based on manufacturers' warranties/credit policies and are subject to restocking fees.

Delinquent accounts are subject to a monthly service fee. There is a $35 service charge on all returned checks.

I have read and understood the HIPAA information from Dr. Pennye Doud and Associates. I have asked any questions I may have and given any specific privacy requests to the office in writing.

Signature: ______________________________ Date: __________________