

## Health History Questionnaire

Please fill out this questionnaire as thoroughly as possible. This information will assist us in caring for your vision and eyes. All information given is confidential. If you are unable to fill out this form please inform the front desk for assistance.

**Patients Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

Please explain the reason for your visit with us today? \_\_\_\_\_

**Do you Wear Glasses?**  NO  YES(Distance Near Bifocal) **Wear Contact Lenses**  NO  YES(Soft Toric Gas Perm Bifocal)

**Are you interested in Contact Lenses( NO YES) or Laser Refractive Surgery ( NO YES)?**

| Do you currently have any problems in the following areas? If yes, please provide the information        |                          |                          |
|----------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
|                                                                                                          | NO                       | YES                      |
| Blurred vision                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor Night vision                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| See Spots in vision                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| See Flashes of Light                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Double vision                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Red Eyes                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Itching                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Foreign Body Sensation                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain in Eyes                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Drooping eyelid                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye turning                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had any problems in the following areas? If yes, please provide the information            |                          |                          |
|                                                                                                          | NO                       | YES                      |
| Eye Surgery                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Macular Degeneration                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision Loss                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Retinal Disease                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Cataracts                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye Trauma                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Please check any of the following conditions your immediate family currently has or has had in the past. |                          |                          |
|                                                                                                          | NO                       | YES                      |
| Diabetes                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Blindness                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Cataracts                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Macular Degeneration                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Lazy Eye                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |

| Do you currently have any problems in the following areas? If yes, please provide the information |                          |                          |
|---------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
|                                                                                                   | NO                       | YES                      |
| Fever                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Gain                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Loss                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Stuffy Nose                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing Loss                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Problems                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Ulcer                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Diarrhea                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Constipation                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Painful Urination                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent Urination                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Back Pain                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Warts                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin Rashes                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin Cancer                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Headache                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Insomnia                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Disease                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| High Cholesterol                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay Fever                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Lupus                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Please list any medical conditions not included above.                                            |                          |                          |

Do you have any allergies to medications (if YES, please list all medications to which you have allergies)?  NO  YES

\_\_\_\_\_

\_\_\_\_\_

Please list all medications you are currently taking (prescription and over-the-counter)?  None \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Occupation: \_\_\_\_\_

Employed by: \_\_\_\_\_

Last Eye Exam Date: \_\_\_\_\_

by: \_\_\_\_\_

Last Medical Exam Date: \_\_\_\_\_

by: \_\_\_\_\_

Do you Smoke?  NO  YES  
(if yes, how much? \_\_\_\_\_)

Do you drink alcohol?  NO  YES  
(if yes, how often? \_\_\_\_\_)

Please include any additional information from boxes indicated YES on this form.

**PATIENT REGISTRATION FORM**

PLEASE PRINT

Today's date: \_\_\_\_\_  
(mo) (day) (yr)

Patient name: \_\_\_\_\_ Nick name: \_\_\_\_\_  
(first) (mi) (last)

Address: \_\_\_\_\_  
(street) (city) (state) (zip)

Date of birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Sex:  male  female  
(mo) (day) (yr)

occupation: \_\_\_\_\_ employer: \_\_\_\_\_  
(name) (city) (state)

Your email address: \_\_\_\_\_

home phone: (\_\_\_\_\_) \_\_\_\_\_ work phone: (\_\_\_\_\_) \_\_\_\_\_ Spouse: \_\_\_\_\_

Family doctor: \_\_\_\_\_  
(name) (city) (state)

Have you been seen or been treated before by Dr. Ditto or Dr. Musick?  No  Yes Estimated date of last visit: \_\_\_\_\_  
(mo) (yr)

Who referred you to us?  have previously been examined or treated here  relative  friend  news article  
 one of our patients  insurance  yellow pages  Dept for the Blind  internet

other: \_\_\_\_\_  
 referred here by another doctor: \_\_\_\_\_ for: \_\_\_\_\_  
(name of doctor) (city) (reason referred)

Do you have any type of medical insurance?  No  Yes:

\_\_\_\_\_  
(NOTE: if you have a medical diagnosis today, your office visit may be able to be filed with your medical insurance) (name of insurance)

Do you have insurance for routine eye exams or glasses?  No

Yes: \_\_\_\_\_ (name of insurance)

**RESPONSIBLE PARTY BILLING INFORMATION**

Name: \_\_\_\_\_ relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (city) (state) (zip)

**FOR ALL PATIENTS: PROTECTED HEALTH INFORMATION CONSENT, INSURANCE AUTHORIZATION & FINANCIAL RESPONSIBILITY**

I give my consent for protected health information to be created, maintained, and used by Kentucky Eye Institute (KEI) for treatment, billing, and/or other health care operations. I give consent to examination and/or treatment by Drs. Ditto, Musick, Patterson and/or Kroggel. I request that payment of authorized Medicare/Medicaid and/or other insurance benefits be made on my behalf to Drs. Ditto and/or Musick or to KEI for any applicable services or products provided to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents or other insurance companies, any information needed to determine these benefits or the benefits for related services. I understand that it is my responsibility to obtain appropriate referrals, when necessary, from my primary care physician or health care plans. I understand that I am responsible for payment of services or products, if applicable, for which I did not obtain a valid or timely referral. I acknowledge that I am responsible for payment at the time of each visit for all services or products provided by Drs. Ditto and Musick, Jessamine Optical or KEI which are not covered by an assigned insurance or agency authorization or for which no prior payment arrangement has been made. I agree to pay all reasonable attorney fees and collection costs in the event of non-payment of my charges.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INSURANCE: PLEASE PRESENT ALL OF YOUR MEDICAL INSURANCE OR VISION PLAN CARD(S) TO THE RECEPTIONIST AT THIS TIME SO WE MAY MAKE COPIES TO ASSIST US IN FILING ANY APPLICABLE INSURANCE CLAIMS FOR YOU. THANK YOU!**

## KENTUCKY EYE INSTITUTE CONSENT FOR PATIENT CONTACT

From time to time, it may be necessary for Kentucky Eye Institute to contact you concerning a variety of issues that pertain to your medical care. While the following list is not all-inclusive, we might need to contact you to:

- Make an appointment
- Cancel an appointment
- Inform you that your glasses or contact lenses are ready to be picked up
- Discuss your medical care and treatment
- Etc.

To assist you with your needs and to address the patient privacy issues described in the Health Insurance Portability and Accountability Act of 1996, we need you to specify the alternative ways we may contact you in the event we cannot reach you personally.

You may contact me by: (please check any box(es) that apply)

- Leaving a message on my home answering machine
- Leaving a message on my work answering machine
- E-mailing me at home \_\_\_\_\_
- E-mailing me at work \_\_\_\_\_
- Leaving a message with anyone who answers my telephone at home
- Leaving a message with anyone who answers my telephone at work
- U.S. mail
- Other (specify): \_\_\_\_\_

In the event you cannot contact me personally, you may discuss my care with any of the following individuals:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

No one

I give my consent for any representative of KEI to contact me regarding my care using the means I have indicated by the checked boxes above. Further, I give my permission to discuss my care with the individuals whose names are listed.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date