MEDICAL QUESTIONNAIRE

SPECTRUM
EYE CARE

Name _____ Date _____

Date of most recent: Medical exam: _____ (MO/YR) Eye exam: _____ (MO/YR)

Primary Care Physician _____

MEDICAL HISTORY

List any known allergies to medications or other substances: _____

List any medications you are currently taking (prescription or otherwise):

_____

Have you recently been hospitalized or had surgery? ☐ YES ☐ NO If so, please indicate why:

_____

REVIEW OF SYMPTOMS Do you currently, or have you EVER had any problems in the following areas:

	YES	NO
VISION		
Blurred vision	☐	☐
Double vision	☐	☐
Eye injury	☐	☐
Eye surgery	☐	☐
Floaters/Flashes	☐	☐
Glare/Halos	☐	☐
Crossed or lazy eye	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐
Dry Eye	☐	☐
Retinal disease	☐	☐
ENDOCRINE (GLANDS)		
Thyroid	☐	☐
Diabetes (PLEASE CIRCLE ONE) (TYPE 1 / TYPE 2)	☐	☐
BONES/JOINTS/MUSCLES		
Rheumatoid arthritis	☐	☐
Joint pain	☐	☐
VASCULAR/HEART		
High blood pressure	☐	☐
Cholesterol	☐	☐

	YES	NO
ALLERGIES	☐	☐
NEUROLOGICAL		
Headaches/Migraines	☐	☐
Seizures	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic bronchitis	☐	☐
Emphysema	☐	☐
SKIN	☐	☐
BLOOD/LYMPH	☐	☐
MENTAL HEALTH	☐	☐
GASTROINTESTINAL	☐	☐
EAR/NOSE/THROAT/MOUTH	☐	☐
GENITOURINARY	☐	☐
Do you use Tobacco products?	☐	☐

FAMILY HISTORY

Please list any family history (parents, grandparents, siblings, and/or children - living or deceased) for the following:

OCULAR CONDITION	Blindness	☐ YES	☐ NO
	Crossed Eyes	☐ YES	☐ NO
	Glaucoma	☐ YES	☐ NO
	Macular degeneration	☐ YES	☐ NO
	Retinal detachment	☐ YES	☐ NO
SYSTEMIC CONDITION	Diabetes	☐ YES	☐ NO
	High blood pressure	☐ YES	☐ NO
	Cancer	☐ YES	☐ NO
	Heart Disease	☐ YES	☐ NO

By signing this form, I consent to treatment for myself and/or on behalf of the Minor for which this information pertains. I give permission for the doctor(s) to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian for Minor and have the authority to authorize care and treatment.

_____ _____

Signature Date

PATIENT INFORMATION

SPECTRUM
EYE CARE

GENERAL INFORMATION

Name _____

Address _____

City, State, Zip _____

Cell Phone _____ Other Phone _____ E-mail _____

☐Male ☐Female Birthdate ____ /____ /____ Age_____ ☐ Single ☐ Married ☐ Widowed ☐ Other

Employer _____ Occupation _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Phone _____

Address _____ City, State, Zip _____

RESPONSIBLE PARTY INFORMATION

Person responsible for account _____

Relationship to Patient _____ Birthdate ____ /____ /____ Social Security # ____ - ____ - ____

Address _____ City, State, Zip _____
(if different than patient)

Employer of person responsible _____ Business Phone _____

INSURANCE INFORMATION

(VISION INSURANCE) Do you have Vision Insurance? ☐Yes ☐No

Insurance Company _____ ID # _____ Group # _____

Address _____ Phone _____

(MEDICAL INSURANCE) Do you have Medical Insurance? ☐Yes ☐No

Insurance Company _____ ID# _____ Group # _____

Address _____ Phone _____

Secondary Insurance _____ ID# _____ Group # _____

Address _____ Phone _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payment directly to all providers of the medical benefits, if any; otherwise payable to me for services rendered by Dr. Ryan S. Orgill, O.D. I understand that I am responsible for any charges incurred by me or any party for whom I am legally responsible. I also agree that in the case of default of payment I will be responsible for any cost incurred in the collection of such account, including reasonable attorney fees and court costs. I hereby waive notice of dishonor, demand, and protest. All exemptions are waived.

I, the undersigned, hereby acknowledge that it is the policy of this office that full payment be made at each visit, and I am responsible for payment to Dr. Ryan S. Orgill for all services rendered to the above patient that are not covered by Medicare assignment, Medicaid, Workman's Compensation, or other benefits agreed by the provider of such services. I certify that the information contained herein is complete and correct. I authorize photocopies of this form to be valid as the original.

Signature of Patient or Guardian _____ Date _____

I acknowledge that I have viewed and been offerered a copy of the privacy policy for Spectrum Eye Care. _____
Please Initial