Medical History Questionnaire

Name: _____Date:_____Tel # (cell)_____

Address:_____E-Mail:_____ (home)_____

City: _____State:_____Zip Code:_____ Male/Female

Birth Date:_____Occupation_____Workplace_____

Contact Lens Information

Yes ☐ **No** ☐ I am interested in being fit and/or updating my current contact lens prescription with the latest innovations in comfortable soft contact lens use, some of which can be worn conveniently and safely overnight. **Most patients of all ages are excellent contact lens candidates**: this includes patients over 40 fit, with bifocal contact lenses. *There exists a separate nonrefundable, and noninsurance submitable fee for all fittings and evaluations*.

I prefer

☐ Colored Contacts Lenses ☐ Clear Contact Lenses ☐ Both Types

☐ Bifocal contact lenses

I require:

☐ a new custom fit

☐ an established wearer's evaluation

Laser Vision Correction

Dr. Magalhaes and his staff are consultants for the latest technology for LASIK procedures. This safe and effective surgery is intended to reduce patients' dependency upon eyeglasses. Please check here if you are interested in a free consultation

☐ No ☐ Yes

If yes, which clinic would you be interested in: ___TLC-Providence ___TLC-Waltham ___LASIK MD – Montreal, Canada (reduced professional fees)

Patient Medical History

Date of last eye exam _____ Dr's Name _____ City _____

Date of last physical _____ Dr's Name _____ City _____

Medications: _____ Allergies: _____

List any major injuries/surgeries to the eyes _____

Circle if you have had any of the following:

Glaucoma *Strabismus* *Keratoconus* *Macular Degeneration* *Injury* *Amblyopia (lazy eye)*

Retinal Hole *Surgery* *Patching* *Retinal Degeneration* *Inflammatory Disorder*

Retinal Detachment *Cataract* *Retinal Hole*

Family History

Please note any family history (parents, grandparents, siblings, children) of the following:

Medical: *Cancer* *Hypertension* *Thyroid* *Diabetes*

Eye Conditions: *Glaucoma Suspect* *Amplypia (lazy eye)* *Strabismus* *Cataract* *Severe Myopia*

Macular Degeneration *Retinal Degeneration* *Severe Hyperopia* *Glaucoma*

Social History

Do you use tobacco products __ Yes __ No

Do you consume alcohol more than socially? __ Yes __ No

Do you use illegal drugs __ Yes __ No

Please list hobbies (helps determine need for type of vision correction) _____

Please complete reverse side

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

Constitution
__ Development Disability
__ Cancer
__ Fatigue Syndrome

Eye Nose Throat
__ Sinusitis
__ Laryngitis
__ Dry Mouth
__ Hearing Loss

Neurological
__ Cerebral Palsy
__ Multiple Sclerosis
__ Stroke/Tumor
__ Epilepsy/Migrane

Psychiatric
__ Depression
__ Anxiety Disorder
__ Attention Deficit
__ Bipolar Disorder

Cardiovascular
__ Vascular Disease
__ Hypertension
__ Stroke/CVA
__ Heart Disease/CHF

Respiratory
__ Asthma
__ Chronic Obstruction
__ Emphysema
__ Cigarette Smoker
__ Sleep Apnea
__ Bronchitis

Gastrointestinal
__ Celiac Disease
__ Acid Reflux
__ Colitis
__ Colitis
__ Ulcer
__ Chron's

Genitourinary
__ Chlamydia
__ Prostate disease/cancer
__ Herpes
__ Pregnant/Nursing
__ STD
__ Benign Prostate/Kidney

Musculoskeletal
__ Osteoporosis
__ Muscular Dystrophy
__ Osteoarthritis
__ Ankylosing Spondylitis
__ Gout/Arthritis
__ Fibromyalgia

Intagumentary
__ Eczema
__ Rosacea
__ Herpes/Cold Sores
__ Herpes/Shingles
__ Psoriasis

Endocrine
__ Thyroid dysfunction
__ Type 2 diabetes
__ Hormonal dysfunction
__ Type 1 diabetes

Hematological/Lymphatic
__ Ulcer
__ Anemia
__ Large Volume blood loss
__ Hypercholesteremia

Allergic / Immune
__ Lupus
__ Drug Allergies/Environm
__ Rheumatoid Arthritis
__ Sjogren's Syndrome

Thank you for choosing us, and our competent doctors among your many choices for eye care. Today you will receive a thorough eye examination and accurate prescription as part of your evaluation. You will also likely receive eye drops for evaluation of eye disease to rule out such maladies as glaucoma, retinal detachment, cataracts, eye tumors and other sight or life threatening conditions that we diagnose on a routine bases. We always prefer to have our patients driven after their dilation, as the eye drops have an affect towards blurred vision and light sensitivity on sunny days. We will offer you reversal drops to help decrease the time of recovery, and also sunglasses to reduce the light sensitivity. Finally, dilation will facilitate the last part of your exam, which is retinal photography. You will find this part very informative and interesting, as we employ the latest technologic advances in eye care today.
Masshealth patients are charged $15 for retinal photos & $25 for anterior photos at the doctors discretion.

Our doctors will review your photos with you as needed, and they will then serve as a baseline to compare against changes in your vision in the future. **Also, our innovative Optos technology will be performed on you today. Most new advances in eye care are not initially covered by insurance. Therefore, we charge a fee of $35 for this service, but we feel this to be a very necessary part of your eye exam experience.** We hope this eye examination will be the best you have ever had, and that you will again look to us for eye care needs in the years to come. Thank you from the staff at Dr. Magalhaes and Associates.

I hereby authorize the use or disclosure of my information to Lenscrafters. Description of information that may be used/ disclosed: My name, address, telephone number, email address and next appointment date(s) and time(s).

Assignment and Release

I authorize payment of benefits directly to Dr. Magalhaes and Associates for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.

I understand that some services may require prior approval from my primary care physician for coverage and that, if I do not obtain that approval, I am financially liable for the services.

I understand that my insurance carrier may not cover some services and products and benefit information does not constitute approval of payment. Deductibles and Fees not paid by my insurance carrier will be my responsibility. I also understand that in the event that I receive a statement for balances owed, I will be charged a $15.00 late fee after 45 days, and a $50.00 collections fee after 90 days of non-payment.

I acknowledge that I was offered a copy of Dr. John Magalhaes and Associates, Inc.'s "NOTICE OF PRIVACY, HIPAA" Policy.

Signature _____ Date _____

If under 18, Signature of responsible party above. Please print name here: _____

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