Medical History Questionnaire

Name: _____ Today's Date_____/_____/_____

Address: _____ Phone:_____

City: _____ State:_____ Zip:_____ Work:_____

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

Name of Medical Doctor: _____ Dr.'s Phone:_____

How did you hear about our office: _____ Last Medical Exam:_____/_____/_____

Occupation:_____ Employer: _____

Medical History

Do you have any allergies to medications? ❑ No ❑ Yes If yes, explain:_____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

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

_____

List 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:_____

Are you pregnant 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 contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ No ❑ Yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions.

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness	❑	❑	_____
Cataract	❑	❑	_____
Crossed Eyes	❑	❑	_____
Glaucoma	❑	❑	_____
Macular Degeneration	❑	❑	_____
Retinal Detachment/Disease	❑	❑	_____
Arthritis	❑	❑	_____
Cancer	❑	❑	_____
Diabetes	❑	❑	_____
Heart Disease	❑	❑	_____
High Blood Pressure	❑	❑	_____
Kidney Disease	❑	❑	_____
Lupus	❑	❑	_____
Thyroid Disease	❑	❑	_____
Other_____	❑	❑	_____

** Please turn this form over and complete side two **

Social History

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

Review of Systems

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

SYSTEM	NO	YES
Fever, Weight Loss/Gain	☐	☐
Skin	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye or Lid	☐	☐
Styes Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐
Tired Eyes	☐	☐
ENDOCRINE		
Thyroid/Other Glands	☐	☐

	NO	YES
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR / CARDIOVASCULAR		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals/Kidney/Bladder	☐	☐
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATIC / HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐
PSYCHIATRIC	☐	☐

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

_____

_____

_____

_____

_____

_____ _____

Doctor's Signatures Date

Authorization

I certify that I have read and understand, to the best of my knowledge, this information. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care, to third party payees and/or healthy practitioners. If applicable, I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on the behalf of my dependents.

_____ _____

Signature Date

Dilation Consent

Please check one. Drs. MacDonald advise dilation.

____ I agree to have my eyes dilated. Light sensitivity and blurry vision are expected for 2-6 hours following this procedure. I understand to be cautious if driving.

OR

____ I decline dilation. I understand its importance and that eye and systemic conditions may go undetected without dilation.

_____ _____

Signature Date

PATIENT PRE-SCREENING QUESTIONNAIRE

Due to the ongoing COVID-19 Pandemic, all caregivers/patients are required to complete this form prior to being seen in our office. Effective immediately, only patients with appointments are allowed in our office. (One parent can accompany minors) These rules are being enforced to keep our patients and staff safe and healthy.

	YES	NO
Has the patient, caregiver or anyone in your household have travelled **outside the US in the past 2 weeks (14 days)** **IF YES, WHERE _____**		
Has the patient, caregiver or anyone in your household have travelled **outside of Florida in the past 2 weeks (14 days)** **IF YES, WHERE _____**		
In the past **2 weeks (14 days)** has the patient, caregiver or anyone in your household had contact with any person **suspected to have contracted coronavirus (COVID-19)**? Including being ***tested*** for COVID-19, & being in ***self isolation*** for COVID-19		
In the past **2 weeks (14 days)** has the patient, caregiver or anyone in your household had contact with any person **confirmed to have contracted coronavirus (COVID-19)**?		
Has the patient or caregiver currently been exposed to someone **with flu-like symptoms (cough, shortness of breath or fever)**		
PLEASE CIRCLE IF SYMPTOMS ARE CURRENTLY BEING EXPERIENCED BY CAREGIVER, PATIENT OR BOTH		
IN THE LAST 72 HOURS HAS THE PATIENT OR CAREGIVER EXPERIENCED		
FEVER		
COUGHING		
SORETHROAT		
DIFFICULTY BREATHING, SHORTNESS OF BREATH OR WHEEZING		
MUSCLE ACHES		
STOMACH PAINS		
VOMITING OR DIARRHEA		
PINK EYE/ RED EYES		
RASH		
FATIGUE OR FEELING UNWELL		

*****Please return this form to the front desk when completed*****

By signing below, you certify that the answers above are true.

Patient/Caregiver:_____ Date:_____

RETINA HEALTH INFORMED CONSENT

Dr. Macdonald uses today's most advanced technologies to provide patients with the most thorough eye health evaluations possible. The **OPTICAL COHERENCE TOMOGRAPHY (OCT)** is a non-invasive imaging test that uses light waves to take cross-section pictures of your retina, the light-sensitive tissue lining the back of the eye. It provides very detailed digital images of your Optic Nerve, Macula and Retina in both 2D and 3D views.

The test will allow us to detect certain eye health problems at the earliest stages, often years before a patient would be aware something was wrong with their vision. Detecting potentially blinding diseases in the earliest possible stages always provides the best chance for preventing permanent vision loss.

With the **OCT** we will be able to more accurately and efficiently evaluate you for:

- Macular Degeneration
- Glaucoma
- Retina Detachments
- Retina Melanomas and other eye cancers
- Diabetic Eye Disease
- Complications from High Blood Pressure
- Optic Nerve Diseases
- Complications from High Cholesterol

The **OCT** consists of a few quick camera flashes. All patients with any of the above conditions must have the images taken at each year's exam so that Dr. MacDonald can provide the most thorough eye health evaluation available. If you have any of the above conditions and refuse the **OCT**, we will not be able to perform your exam, as the screening has become the standard of care. Dr. MacDonald *will not* compromise the health portion of the exam.

The **OCT** may be covered by most major health insurance plans if we detect one of the above conditions. Some vision plans will cover the screening with a copay. If we are unable to bill your insurance for the **OCT** images, the fee is $75. Please sign below to acknowledge all stated above.

_____ _____

Signature of patient or Parent/Guardian Date

MacDonald Family EyeCare

1122 SR 434 Suite 1000
Winter Springs, Florida 32708

In a continued effort to improve your experience as a patient in our practice, we would like to restate some of our office policies regarding products and services.

Prescriptions

- We at MacDonald Family EyeCare can provide all your eye services. This includes eye examinations, contact lens evaluations, eyeglasses and/or contact purchases.
- In addition, if you choose to have a copy of your prescription it will be provided upon request. Specific measurements* and/or adjustments can be provided by our office – see sales associate for details.

Contact Lenses

- A comprehensive exam includes a prescription for glasses and a thorough health check of the eye. When a patient is interested in contacts, the doctor must evaluate the patient to determine the health of the cornea as well as the curvature and prescription of the contact lenses. *This additional exam* is done after the comprehensive exam and is subject to a $60 or $80 fee, depending on the prescription. The contact lens evaluation fee includes the initial fitting and any subsequent follow-ups that are needed until the final prescription is determined. The contact lens fitting must be done within 90 days of the comprehensive exam. A new comprehensive exam and contact lens fitting will be required otherwise.
- All disposable contact lens prescriptions are valid for 1 year from the initial exam. All RGP (Rigid Gas Permeable) prescriptions are valid for 2 years.
- All patients will have 2 weeks to return for contact lens follow up from the initial exam date. Patients using vision insurance will have to 30 days to finalize their contact lens prescription. Insurance will be filed after 30 days.

Glasses

- Ophthalmic lenses are customized for each patient and can only be used for that particular patient. If an order for glasses must be cancelled, the patient will have 48 hours from when the order was originally placed to receive a full refund. If the order is cancelled after 48 hours, there will be a 50% refund on lenses and a $10.00 restocking fee for the frame.
- All progressive addition lenses (Also called PAL, invisible or no-line bifocals) have a slight optical distortion in the outer portions of the lens which can make some objects appear bowed or curved, or can cause a feeling of motion when the head is turned. The reading zone in progressive lenses is wide enough for most purposes, but it may be narrower than some other lined bifocal styles. These factors are usually minor and subside with use. While most people are not bothered by these characteristics, some are unable to adapt. In these cases, our office – or your insurance company – will make new lenses in any other lens design that you wish, at no charge within 30 days of dispensing. There will be no refunds or credits for the difference in cost if the remade lenses are of lesser value.

Payment

- We gladly accept all forms of payment for our services, with the exception of checks.

Patient Name _____

Patient Signature _____ Date: _____

*An additional charge may apply for specific services and certain restrictions.