BAYOU VISION
ASSOCIATES

Patient History Questionnaire

Date: _____

Last Name: _____ **First:**_____ **Middle Initial:**_____**Nickname:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone/Home: _____ Cell**:** _____ **Work:** _____

Email: _____

Preferred Method of Contact: __email for recall __text msg for appointment notification
__text msg for order notification __phone call for appt notification __phone call for order notification

Date of Birth: _____ **Gender:** _____ **SSN:** _____ or Last 4 _____

Occupation: _____ Employment **Status:** ___Retired ___Part time ___Full time ___Student

Marital Status: ___Single ___Married ___Divorced ___Widowed **Hobbies/Activities:** _____

Race: ___Black or African American ___White ___American Indian ___Asian ___Other_____

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino **Preferred Language**:__English ___Other_____

Referred By: _____

Family Doctor: _____ Last Physical/Medical Exam: _____

Responsible Party

Name of person responsible for this account_____ Relationship to patient_____

Phone (Home): _____ Cell: _____

***Insurance (circle all that apply)*:** **NONE** **MEDICARE** **MEDICAID** **PRIVATE**

Medical Insurance_____ ID #:_____Group #_____

Vision Insurance_____ ID #:_____Group #_____

Name of subscriber: _____ Relationship to patient: _____

Employer: _____ Date of Birth: _____ SSN: _____

Medical History

Please circle if you have the following: **Diabetes:** No / Yes___If Yes: Type_____ **High Blood Pressure:** No / Yes

High Cholesterol: No / Yes **Heart Disease:** No / Yes_____ **Thyroid Disease:** No / Yes_____

Cancer: No / Yes_____ **Other:** _____

Are you Pregnant? No / Yes

Please list major surgeries, injuries or hospitalizations you have had: _____

Ocular History

Do you have or have you had the following (please circle all that apply):

Blepharitis Cataracts Diabetic Retinopathy Dry Eyes Other_____

Eye injury Glaucoma Macular Degeneration Lazy Eye _____

Do you wear eye glasses? No / Yes: How old are your current glasses? _____

Do you wear contacts? No / yes: circle: soft lenses or hard lenses **Are you interested in Contacts? Y / N**

Ocular Surgeries: _____

List Medications that you currently take (including over the counter supplements and vitamins)

_____

_____

Allergies to medications: No / yes: _____

Last Eye Exam: _____ Location: _____

Social History

This information is kept strictly confidential. However you can discuss this directly with your doctor if you prefer.

____I would prefer to discuss my social history information directly with my doctor.

Do you drive? Yes / No / Daytime only

Computer Usage (Hrs/day):_____

Hobbies: _____ Special Needs: _____

Do you use: Tobacco products: No / Yes: Type_____ Amount per day_____ How long_____

Alcohol: No / Yes: Amount per Day_____

Have you ever been exposed or infected with: Hepatitis: No/ Yes HIV/ AIDS: No/ Yes

Family History (If yes, Please note parent, grandparent, sibling, children)

Cataract: No / Yes_____ Retinal Disease/Detachment: No / Yes_____

Glaucoma: No / Yes_____ Diabetes: No / Yes_____

Macular Degeneration: No / Yes_____ High Blood Pressure: No / Yes_____

Dilation

We use dilation eye drops to dilate or "open up" the pupil of the eye. This allows for better observation of the internal structures of the eye- to more easily detect ocular diseases. If the doctor feels it is necessary to dilate your eyes at this visit, ***please circle:***

Yes- I agree to have my eyes dilated.

No- I have read the above and I do not want my eyes dilated.

Bayou Vision Associates

RELEASE OF INFORMATION, GUARANTEE OF PAYMENT, SIGNATURE FOR FILE:

I authorize Bayou Vision Associates to release to the Social Security Administration, Centers for Medicare & Medicaid Services, its intermediaries or my medical/vision insurance carrier any information needed for a medical/vision claim.

I permit a copy of this authorization to be used in place of the original, and request payment of medical/vision insurance benefit either to myself or to Bayou Vision Associates/Jessica E. Stafford, O.D...

Insurance companies do not guarantee payment. In the event the services I receive in this office are not covered by my insurance, I understand that I am responsible for all unpaid charges, and further agree to pay any and all costs associated with these fees.

The HIPAA Privacy Act requires us to keep your medical information private. Please sign acknowledging that you were offered a copy of the HIPAA document, and have given your consent for our office to verify, authorize and file insurance claims for you and/or your dependents behalf.

PRINT NAME OF PATIENT OR RESPONSIBLE PARTY_____

SIGNATURE: _____Date:_____