MID-SOUTH RETINA ASSOCIATES, LLC

MEDICAL AND OCULAR HISTORY QUESTIONNAIRE

Patient Name: _____ Age: ____ Occupation: _____ Date:_____

Referring Physician: _____ Primary Care Doctor: _____

PAST MEDICAL HISTORY: (Circle)

Diabetes : type 1 type 2	High Blood Pressure	Heart Failure	Thyroid Disorder	Tuberculosis	Arthritis
Duration :_____	Heart Attack	Emphysema	AIDS/HIV	Lupus	Cancer
A_1C: _____	Stroke	Asthma	Leukemia	Lymphoma	Sarcoid
Last Glucose:_____					

LIST ANY MAJOR ILLNESSES: _____

List All Medications Currently Using: ☐ **List Provided and Attached**

Medicine	Dose	Times Per Day
1._____		1 2 3 4
2._____		1 2 3 4
3._____		1 2 3 4
4._____		1 2 3 4
5._____		1 2 3 4
6._____		1 2 3 4
7._____		1 2 3 4
8._____		1 2 3 4
9._____		1 2 3 4
10._____		1 2 3 4
11._____		1 2 3 4
12._____		1 2 3 4

Drug Allergies: (Circle)

Latex	Sulfa
Penicillin	Tetracycline
Aspirin	Cipro
Contrast Dye	Iodine

Other Allergies: _____

_____

_____

_____

Circle any of the surgical procedures patient has had and list any additional surgeries not circled in space provided.

Tonsillectomy	Hysterectomy (removal uterus/ovaries)
Prostate Surgery	Heart Bypass
Gall Bladder Removal	Lumbar Discectomy (back surgery)

Anesthetic Complications: Yes No

Cataract Surgery: Right Left

Retina Reattachment: Right Left

Other Surgeries:_____

_____

_____

Hospitalizations:_____

For:_____

Eyes:	**Yes**	**No**	**Right**	**Left**
Loss of Vision	☐	☐	☐	☐
Loss of Vision (<5 minutes)	☐	☐	☐	☐
Blurred Vision	☐	☐	☐	☐
Distorted Vision (straight lines crooked)	☐	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐	☐
Previous Eye Disease or Treatment:_____	☐	☐		

	Yes	**No**	**Right**	**Left**
Floaters	☐	☐	☐	☐
Flashes of Light	☐	☐	☐	☐
Loss of Side Vision	☐	☐	☐	☐
Eye Pain/Soreness	☐	☐	☐	☐
Double Vision				
Burning	☐	☐	☐	☐
Lazy Eye/Amblyopia	☐	☐	☐	☐

Does visual problem affect daily activities? (Explain)_____

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MEDICAL AND OCULAR HISTORY QUESTIONNAIRE

REVIEW OF RECENT HEALTH (SYSTEMS)

Constitutional Symptoms	**Yes**	**No**
Fever/Chills	☐	☐
Weight Loss	☐	☐
Fatigue	☐	☐
Night Sweats	☐	☐

Rheumatology	**Yes**	**No**
Lyme Disease	☐	☐
Other	☐	☐

Describe:_____

_____

Ear, Nose, Throat, Mouth	**Yes**	**No**
Sinus Congestion	☐	☐
Sore Throat	☐	☐
Runny Nose	☐	☐
Cold Sore Lip/Mouth	☐	☐
Cardiovascular	☐	☐
Chest Pain (Angina)	☐	☐
Rapid Heartbeat	☐	☐
Heart Skips Beat	☐	☐
Short of Breath Walking	☐	☐
Enlarged Heart	☐	☐
Respiratory (Breathing/Lungs)	☐	☐
Cough	☐	☐
Difficulty Breathing	☐	☐
Asthma Attacks	☐	☐
Allergy	☐	☐
Seasonal Allergies	☐	☐
GU (Kidney/Bladder/Genitals)	☐	☐
Blood in Urine	☐	☐
Burns to Urinate	☐	☐
Sores on Genitals	☐	☐
Kidney Stones	☐	☐
Renal Failure	☐	☐
Dialysis	☐	☐

GI (Stomach/Intestines)	**Yes**	**No**
Diarrhea	☐	☐
Constipation	☐	☐
Blood in BM	☐	☐
Cramps/Pain	☐	☐
Skin	☐	☐
Tick Bites	☐	☐
Rashes	☐	☐
Reproductive	☐	☐
Pregnant	☐	☐
Last Menstrual Period	_____	
Neuro	☐	☐
Loss of Balance	☐	☐
Headaches	☐	☐
Weakness Arm/Leg	☐	☐
CVA/Stroke	☐	☐
Numbness of Arm/Leg	☐	☐
Seizure Disorder	☐	☐
Hematologic (Blood/Lymph)	☐	☐
Anemia (Low Blood Count)	☐	☐
Abnormal White Blood Cells	☐	☐
Swollen Lymph Nodes	☐	☐
Bleeding Disorder	☐	☐
Sickle Cell Disorder	☐	☐

FAMILY HISTORY	**Yes**	**No**	**Relationship to Patient**
Blindness	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
Heart Attacks	☐	☐	_____
High Blood Pressure	☐	☐	_____
Tuberculosis	☐	☐	_____
Stroke	☐	☐	_____
Other	☐	☐	_____

SOCIAL HISTORY

Married **Yes**_____ **No**_____

Do you use drugs for pleasure? **Yes**_____**No**_____

SMOKING STATUS (Circle)

Current smoker Chewing nicotine product

Former smoker Previous history of Chewing tobacco

Never smoked Using nasal snuff

Current every day smoker

Current some day smoker

Attempting to quit using chewing tobacco

Recently quit using chewing tobacco

Patient Signature:_____ **Date:** _____

_____**(For office use below)**_____

Physician Signature:_____ Date: _____

Tech Update: Initial: _____Date:_____ Initial: _____Date:_____ Initial: _____Date:_____ Initial: _____Date:_____

Initial: _____Date:_____ Initial: _____Date:_____ Initial: _____Date:_____ Initial: _____Date:_____

Registration : **Mid-South Retina Associates**

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home Phone Work Phone Cell Phone	How did you hear of us?
Address 2	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Phone

Pref Language:	**Race:**	**Ethnicity:**	**County:**

Provider	**Family Physician**	**Referring Physician**

Medical Insurance	**Name & Address**	**Policyholder**	**Relationship**	**Copay**	**Policy ID**	**Group ID**
1						
2						
3						

Policyholders/Guarantors (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work Phone	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work Phone	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work Phone

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work Phone

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Mid-South Retina Associates **,** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	**Signature Date**	**Mid-South Retina Associates**	
X		PO Box 1000, Dept. 448 Memphis, TN 38148	Phone: 800-488-2217 Email:

Please attach all pertinent insurance ID cards for photocopying.