MID-SOUTH RETINA ASSOCIATES, LLC

MEDICAL AND OCULAR HISTORY QUESTIONNAIRE

Patient Name: ___________________________________ DOB:_____________ Age:____ Occupation:____________________

Referring Physician: _________________________________ Cardiologist:____

Primary Care Doctor: _______________________________ Nephrologist:____

Pulmonologist:____

PAST 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: ____

Dialysis: Y / N Clinic: ____

List All Medications including Vitamins/Supplements:

❑ **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**

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 Disectomy (back surgery)

Anesthetic Complications: Yes No

Other Surgeries:____

____

____

Cataract Surgery: Right Left

Retinal Reattachment: Right Left

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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Patient Name: ______________________________ DOB: ______________

REVIEW OF RECENT HEALTH (SYSTEMS)

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

Ear, Nose, Throat, Mouth	Yes	No
Sinus Congestion	❑	❑
Sore Throat	❑	❑
Runny Nose	❑	❑
Cold Sore Lip/Mouth	❑	❑

Cardiovascular	Yes	No
Chest Pain (Angina)	❑	❑
Rapid Heartbeat	❑	❑
Heart Skips Beat	❑	❑
Short of Breath Walking	❑	❑
Enlarged Heart	❑	❑

Respiratory (Breathing/Lungs)	Yes	No
Cough	❑	❑
Difficulty Breathing	❑	❑
Asthma Attacks	❑	❑

Allergy	Yes	No
Seasonal Allergies	❑	❑

GU (Kidney/Bladder/Genitals)	Yes	No
Blood in Urine	❑	❑
Burns to Urinate	❑	❑
Sores on Genitals	❑	❑
Kidney Stones	❑	❑
Renal Failure	❑	❑
Dialysis	❑	❑

Rheumatology	Yes	No
Lyme Disease	❑	❑
Other	❑	❑

Describe: ______________________________

____

GI (Stomach/Intestines)	Yes	No
Diarrhea	❑	❑
Constipation	❑	❑
Blood in BM	❑	❑
Cramps/Pain	❑	❑

Skin	Yes	No
Tick Bites	❑	❑
Rashes	❑	❑

Reproductive	Yes	No
Pregnant	❑	❑
Last Menstrual Period	❑	❑

Neuro	Yes	No
Loss of Balance	❑	❑
Headaches	❑	❑
Weakness in Arm/Leg	❑	❑
CVA/Stroke	❑	❑
Numbness of Arm/Leg	❑	❑
Seizure Disorder	❑	❑

Hematologic (Blood/Lymph)	Yes	No
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	Yes	No
Married	❑	❑
Do you use drugs for pleasure?	❑	❑

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 days smoker	
Attempting to quit using chewing tobacco	
Recently quit using chewing tobacco	

Patient Signature ______________________________ **Date:** ______________

(FOR OFFICE USE BELOW)

Physician Signature: ______________________________ Date: ______________

Height: __________ Weight: __________ BMI: __________

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

Address 2

Home Phone

Work Phone

Cell Phone

How did you hear of us?

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

X

Signature Date

Mid-South Retina Associates

PO Box 1000, Dept. 448

Memphis, TN 38148

Phone: 800-488-2217

Email:

Please attach all pertinent insurance ID cards for photocopying.