

Medical History Questionnaire

Name: _____ Today's Date: ____/____/____
 Address: _____ Phone: () _____
 _____ Work Phone: () _____
 Date of Birth: ____/____/____ Social Security #: ____ - ____ - ____ Last Eye Exam: ____/____/____
 Name of Medical Doctor: _____ Dr's Phone #: () _____
 Last Medical Exam: ____/____/____

MEDICAL HISTORY

Do you have any allergies to medications? no yes If yes, explain: _____

List all 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: _____

Circle the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts eye infections, eye injury. Explain: _____

Are you pregnant and/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? yes no

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

- Please complete reverse side -

Social History

This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

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	?		NO	YES	?
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES				RESPIRATORY			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR/CARDIOVASCULAR			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Doctor's Signature

Date

Examination

DATE: _____

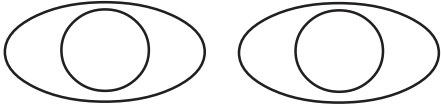
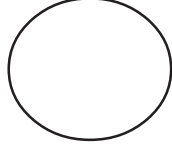
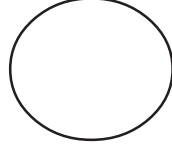
PATIENT: _____ SEX: M F DOB: _____ LAST EXAM: _____

CHIEF COMPLAINT: _____

HISTORY

HPI: Symptoms: Location: Quality: Severity: Duration: Timing: Context: Modifiers:	Allergies: Medications: Ocular ROS: Medical History & ROS from ____/____/____ reviewed: <input type="checkbox"/> no changes (Date) _____ _____ (OD Initials)
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EXAMINATION

Head/Face <input type="checkbox"/> nl		Psych: Mood/Affect (anxiety/agitation/depression) <input type="checkbox"/> nl		Neuro: Oriented (person/time/place) <input type="checkbox"/> y <input type="checkbox"/> n	
VA	sc<	cc<	ph<	near<	glare<
K:	OD _____	OLD RX: OD _____	add _____		
	OS _____	OS _____	add _____		
		REF: OD _____ 20/____	add _____		
		OS _____ 20/____	add _____		
CVF: <input type="checkbox"/> nl	ADNEXA / EYELIDS: <input type="checkbox"/> nl				
MOTILITY: <input type="checkbox"/> Full	<input type="checkbox"/> Blepharitis OD OS OU				
COVER TEST: <input type="checkbox"/> Eso _____ <input type="checkbox"/> Exo _____	<input type="checkbox"/> Meibornianitis OD OS OU				
PUPILS: <input type="checkbox"/> no afferent defect <input type="checkbox"/> round OU		Size: OD _____			<input type="checkbox"/> Indent
		OS _____			<input type="checkbox"/> 14D
					<input type="checkbox"/> 28D
					<input type="checkbox"/> 78D
					<input type="checkbox"/> 96D
					<input type="checkbox"/> 3 Mirror
					<input type="checkbox"/>
SLE: OD OS		RETINA: OD OS			
<input type="checkbox"/> nl	<input type="checkbox"/> TBUT: _____	TEAR FILM	<input type="checkbox"/> nl	<input type="checkbox"/> drusen	MACULA
<input type="checkbox"/> nl	<input type="checkbox"/> arcus	CORNEA	<input type="checkbox"/> nl	<input type="checkbox"/> RPE chngs	<input type="checkbox"/> nl
<input type="checkbox"/> nl	<input type="checkbox"/> pteryglum		<input type="checkbox"/> nl	<input type="checkbox"/> PVD	VESSELS
<input type="checkbox"/> nl	<input type="checkbox"/> injection	SCLERA	<input type="checkbox"/> nl	<input type="checkbox"/> PVD	VITREOUS
<input type="checkbox"/> nl	<input type="checkbox"/> pinguecula	CONJ.	<input type="checkbox"/> nl	<input type="checkbox"/> _____	PERIPHERY
<input type="checkbox"/> D&Q	<input type="checkbox"/> rubeosis	AC	<input type="checkbox"/> D&Q		
<input type="checkbox"/> nl	<input type="checkbox"/> clear	IRIS	<input type="checkbox"/> nl		
<input type="checkbox"/> clear		LENS	<input type="checkbox"/> clear		
				OPTIC DISCS: OD OS	
				<input type="checkbox"/> nl	SIZE/APPEARANCE/NFL
				<input type="checkbox"/> _____	C/D
				<input type="checkbox"/> _____	
T / @	App	DILATED: M .5% 1% C 1% 2% N 2.5% 10%	OU @ _____		

DIAGNOSIS / PLAN

RTO:

_____, OD

EVALUATION & MANAGEMENT WORKSHEET

In order to determine the most appropriate E/M service code to describe a patient visit, "score" the visit in the following four areas: 1) **History**, 2) **Examination**, 3) **Medical decision-making**, and 4) **Category of Service**.

STEP ONE: Determine the amount of **HISTORY** obtained.
To qualify for a given level, all elements listed for that level must be met or exceeded.

<input type="checkbox"/> 1. Problem-Focused	<input type="checkbox"/> 2. Expanded Problem-Focused	<input type="checkbox"/> 3. Detailed	<input type="checkbox"/> 4. Comprehensive
> Chief complaint > 1 to 3 elements of History of Present Illness (HPI)	> Chief complaint > 1 to 3 elements of HPI > Ocular review of systems	> Chief complaint > 4 elements of HPI > Ocular review of systems > 1 specific item from past, family, or social history	> Chief complaint > 4 elements of HPI > Ocular review of systems > Review of 9 additional systems > 1 or more items from all 3 history areas (for new patients); 1 or more items from 2 of the 3 history areas (for established patients)

STEP TWO: Determine the extent of **EXAMINATION** performed.
To qualify for a given level, all elements listed for that level must be met or exceeded.

<input type="checkbox"/> 1. Problem-Focused	<input type="checkbox"/> 2. Expanded Problem-Focused	<input type="checkbox"/> 3. Detailed	<input type="checkbox"/> 4. Comprehensive
> Limited exam of the affected body area or organ system > 1 to 5 elements of eye exam documented	> Limited exam of the affected body area or organ system and other symptomatic or related organ systems > 6 elements of eye exam documented	> Extended exam of the affected body area and other symptomatic or related organ systems > 9 elements of eye exam documented	> Complete single system specialty exam > All elements of eye exam plus mental status documented

STEP THREE: Determine the complexity of **MEDICAL DECISION-MAKING** involved.
To qualify for a given level, two out of three criteria listed for that level must be met or exceeded.

	<input type="checkbox"/> 1. Straightforward	<input type="checkbox"/> 2. Low Complexity	<input type="checkbox"/> 3. Moderate Complexity	<input type="checkbox"/> 4. High Complexity
Number of Diagnostic and Treatment Options	Minimal	Limited	Multiple	Extensive
Amount and Complexity of Data	Minimal or None	Limited	Moderate	Extensive
Risk of Complications and/or Morbidity/Mortality	Minimal	Low	Moderate	High

STEP FOUR: Identify the **CATEGORY OF SERVICE**.

New Patient:

Must meet or exceed 3 of 3 in the column to bill for that code level

	99201	99202	99203	99204	99205
History	1	2	3	4	4
Exam	1	2	3	4	4
Decision	1	2	2	3	4

Consult Patient: (Office Confirmatory consultation):

Must meet or exceed 3 of 3 in the column to bill for that code level

	99241/71	99242/72	99243/73	99244/74	99245/75
History	1	2	3	4	4
Exam	1	2	3	4	4
Decision	1	2	2	3	4

Established Patient:

Must meet 2 of 3 in the column to bill for that code level

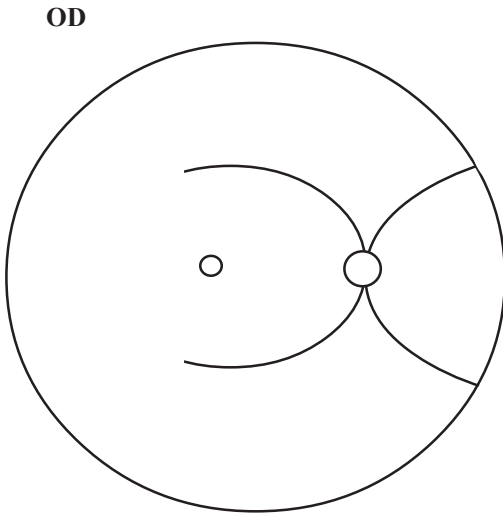
	99211	99212	99213	99214	99215
History	1	2	3	4	4
Exam	1	2	3	4	4
Decision	1	2	2	3	4

Examination: SUPPLEMENTARY TESTS

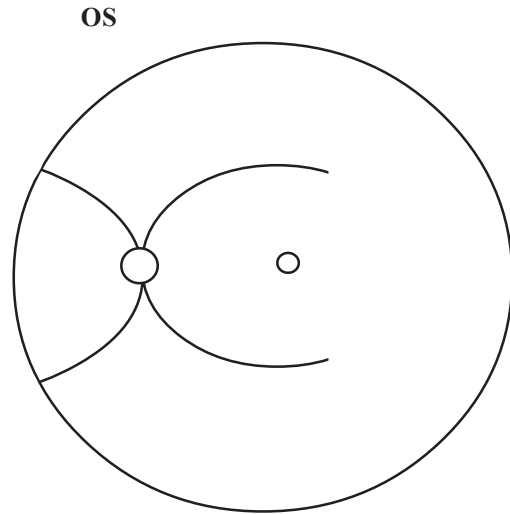
Patient: _____ Date: _____

Extended Ophthalmoscopy (92225, 92226):

- 78D Lens 90D Lens 20D Lens 2.2D Lens 3-Mirror Scleral depression



Interpretation and Report



Interpretation and Report

Fundus Photography (92250): 35mm 35mm/Stereo Polaroid Digital

Interpretation and Report

OD: _____

OS: _____

Visual Fields (92081, 92082, 92083):

Interpretation and Report

OD: _____

OS: _____

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to David MacDonald, OD on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Lifetime Patient Signature

Date

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Lifetime Patient Signature

Date

MEDICARE

Medicare # _____

Effec.Date _____

Birthdate _____

COVERAGE OVERVIEW

As one of our patients age 65 and older, Medicare is your primary health insurance. For your convenience, our office is a participating provider with Medicare. This means that our office bills Medicare for your office visits, tests and materials. Medicare then reviews all submitted claims and if approved, reimburses our office 80% of the approved amount. The remaining 20% (the co-payment) is your responsibility as the Medicare beneficiary. You may also be responsible for a deductible and certain non-covered fees, as described below. Our office may elect to: 1) bill you directly for your portion of the fees, or 2) bill your **supplemental insurance**, if you carry it.

Suppl. Ins. No Yes Carrier Name _____
Address _____
Policy # _____ Effec. Date _____

DEDUCTIBLE

Medicare has a yearly deductible of \$100 that takes effect each January. If our office is the first to submit Medicare claims for you each year, Medicare will notify us that you have not yet met your deductible for the year. Medicare will not pay for your allowable fees until the deductible has been met.

EXCEPTIONS, NON-COVERED SERVICES & MATERIAL FEES

- Medicare does not pay for **refractive services**. This is the part of your eye exam that determines your prescription.
- Medicare will only pay for services that it determines to be “**reasonable and necessary**” under code section 1862(a)(1). If Medicare determines that a particular service, although it would be otherwise covered, is not “reasonable and necessary” under their standards, Medicare will deny payment for that service. The doctor believes that, in your case, Medicare is likely to deny payment.

For _____ because _____

For _____ because _____

For _____ because _____

AUTHORIZATION STATEMENT/SIGNATURE

I have read and understand the information above and agree to pay for any services which are not covered by Medicare.

Patient/Beneficiary Signature _____ Date _____

Print Name _____