

**McNeel EYE CENTER**  
4270 N. Eagle Road, Boise, ID 83713 \* 208-938-2010

<b>PATIENT INFORMATION:</b>		<b>** PLEASE PRINT **</b>	
Last Name:		Date of Birth: ____/____/____ (MM/DD/YYYY)	
First Name:	MI:	Sex: Male ____ Female ____	
*PHYSICAL Address:		Marital Status: Single/Married/Divorced/Sep/Widowed	
City:		Social Security #:	
State:	Zip:	Email Address:	
Home PH#:		Preferred Pharmacy:	
Cell PH#:		Location:	
** Ethnicity: Hispanic/Not Hispanic/REFUSED to specify		Name of Employer:	
** Race: American Indian/Asian/Hawaiian or Pacific Islander		Occupation:	
Black or African American/White/Hispanic/Other			
REFUSED to Specify			
** Language: English/Spanish/Russian/Indian/Other			
<b>RESPONSIBLE/BILLING PARTY:</b>		<b>EMERGENCY CONTACT INFO:</b>	
Name:		Last:	
Relationship to patient:		First:	
Date of Birth ____/____/____ (MM/DD/YYYY)		Relationship to Patient:	
*BILLING Address:		Physical Address:	
City:		City:	
State:	Zip:	State:	Zip:
Home Ph#:		Home Ph#:	
Cell Ph#:		Cell Ph#:	
<b>INSURANCE INFO: (present card at check in – this will be scanned into your file)</b>			
Insurance Company name:		Insured's Name:	
		ID#:	Co-Pay \$
Address:		Insured's relationship to Patient:	
City:		Group #	
State:	Zip:	Insurance phone#:	
Name of Secondary Insurance:		Secondary Insurance ID#:	

\_\_\_ I authorize that any test results can be left by either voicemail or with person at phone# \_\_\_\_\_

Who can we thank for referring you to us? \_\_\_\_\_

**\*The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for ANY balance. I also authorize McNeel Eye Center or insurance Co. to release any information required to process my claims. Typing my name below is an electronic signature.**

X \_\_\_\_\_ Date: \_\_\_\_\_  
Patient/guardian name & signature

# MEDICAL HISTORY QUESTIONNAIRE

## VISION HISTORY:

Are you having difficulties with your vision? **YES NO** If yes, please explain below.

When was your last eye exam? \_\_\_\_\_ Where was your last exam? \_\_\_\_\_

Do you currently wear glasses? **YES NO** If yes, how old is your current pair? \_\_\_\_\_

Do you wear contact lenses? **YES NO** If yes, how old are your contacts? \_\_\_\_\_

What type of Contacts do you wear? Gas Permeable Soft Extended Wear Disposable Overnight

If you wear disposable contact lenses, how often do you replace them? \_\_\_\_\_

What type of solution do you use to clean your contact lenses? \_\_\_\_\_

Please list any eye procedures and/or surgeries, date & physician \_\_\_\_\_

Please circle any of the following eye condition you have had:

Crossed Eyes Lazy Eye Droopy Eyelid Protruding Eye/s Retinal Disease

Cataracts Eye Infections Eye Injury Macular Degeneration Glaucoma

## PERSONAL MEDICAL HISTORY:

List all medications you currently take (including over the counter, oral contraceptives, aspirin & home remedies)

Do you have allergies to any medications? **YES NO** If yes, please list medication and side effect/reaction

List any other major surgeries and/or hospitalizations, date and treating physician \_\_\_\_\_

Do you smoke? Y / N. How often? \_\_\_\_\_ FEMALES, are you currently pregnant or nursing? \_\_\_\_\_

Please note any medical history for the following conditions

		IF yes, please explain
Respiratory problems (shortness of breath, cough)	NO YES	_____
Chronic fatigue, fever, unexpected weight gain/loss	NO YES	_____
Ear, Nose or Throat problems	NO YES	_____
Skin Condition (rashes, dryness)	NO YES	_____
Musculoskeletal problems	NO YES	_____
Heart Problems (disease, irregular beat)	NO YES	_____
Cancer	NO YES	_____
Diabetes	NO YES	_____
High Cholesterol	NO YES	_____
Kidney Disease	NO YES	_____
Liver Disease	NO YES	_____
Thyroid Disease	NO YES	_____
Neurological Problems (numbness, paralysis)	NO YES	_____
Headaches/Migraines	NO YES	_____
Psychiatric problems (depression, anxiety)	NO YES	_____
Stroke or TIA	NO YES	_____
OTHER _____		_____

## FAMILY HISTORY:

Are there any other medical or eye diseases that run in the family (heart disease, diabetes, cancer, ANY eye disease)

**YES NO**, If yes, please specify \_\_\_\_\_