Medical History Questionnaire
Jenkins Vision Care
850 Prince Ave Ste B
Athens, GA 30606

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip Code E-mail

Birth Date: ___ / ___ / ___ Home Phone: _____ Cell Phone: _____

Name of Employer: _____ Occupation: _____

Work Phone: _____ Name of Primary Insurance Carrier: _____

Primary Insured's Name: _____ Relationship: _____ Primary Insured's DOB ___ /___ /___

Secondary Insurance Carrier: _____ Secondary Insured's Name _____

Relationship: _____ Secondary Insured's DOB ___ /___ /___

Date of last Health Exam: ___ /___ / ___ Name of Medical Doctor: _____

MEDICAL HISTORY

List any medications that you are currently taking (including oral, contraceptives, aspirin, over the counter and home remedies).

_____

_____

Do you have any allergies to medications? ☐ Yes ☐ No If yes, please list.

_____

List all major injuries, surgeries and/or hospitalizations you have had.

_____

Date of Last Eye Exam _____

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections, eye injuries.

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, which brand? _____

Type of contact lenses? ☐ Rigid ☐ Soft ☐ Overnight Wear Are they comfortable? ☐ Yes ☐ No

Are you interested in contact lenses? ☐ Yes ☐ No

FAMILY HISTORY

Disease/Condition	Yes	No	Relationship
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____

Disease/Condition	Yes	No	Relationship
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Thyroid Disease	☐	☐	_____
Other_____	☐	☐	_____

REVIEW OF SYSTEMS **Do you currently, or have you ever had any problems in the following areas?**

	Yes	No	Currently
Constitutional			
Fever, Weight loss/Gain	☐	☐	☐
Integumentary			
Skin	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of vision	☐	☐	☐
Blurred vision	☐	☐	☐
Distorted vision / Halos	☐	☐	☐
Loss of side vision	☐	☐	☐
Double vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes in Vision	☐	☐	☐
Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid/Other Gland	☐	☐	☐

Ears, Nose, Mouth, Throat	Yes	No	Currently
Allergies / Hay fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic cough	☐	☐	☐
Dry Throat / Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular / Cardiovascular			
Diabetes	☐	☐	☐
Heart pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Genitals/Kidneys/Bladder	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Allergic/Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

Doctors Signature: _____ Date: ___ / ___ / ___

SOCIAL HISTORY *(This is strictly confidential. You may discuss this information directly with the doctor).*

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
If yes, please describe_____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long. _____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long. _____

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long. _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

DILATION

Dilation of the eyes is an important part of the eye exam. This allows the doctor to examine the internal structures of your eyes for the presence of certain conditions including diabetes, glaucoma, cataracts, and macular degeneration, among others. The dilation drops may cause temporary light sensitivity and blurred near vision for about 3-4 hours, although it should not affect your ability to drive. This procedure is included in today's exam fee. Dilation may be rescheduled for another visit, but an additional fee may be charged at that time.

☐ I Do ☐ I Do Notgive permission to have my eyes dilated.

****Are you pregnant or nursing? ☐ YES ☐ NO ****

Office Policy on Payment and Acknowledgement of Receipt:

I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me if JVC is in contract with that particular insurance company. It is my responsibility to pay any deductible, copay, or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider. I understand that my insurance information MUST be presented at the time of service in order for JVC to file a claim on my behalf, if not, then I understand that I am responsible for the fees out of pocket.

Signature: _____ Date: ___ / ___ / __
Must be at least 18 to sign, or parent or guardian

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ [Please print your full legal name here] (the "Patient" or "Patients legal representative", have been presented with the Notice of Privacy Policy (the "Policy") of *N.E. Ga. Vision Care, P.C. (dba Jenkins Vision Care)* and have been offered a copy of such policy to keep.

[Please initial **one** of the following]

___ I hereby acknowledge that I have been provided with a copy of the Policy.

___ I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.

Signature: _____ Date: ___ / ___ / ___
Must be at least 18 to sign, or parent or guardian

Jenkins Vision Care:

Authorization for Release of Information to Family Members

Patient Name _____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Jenkins Vision Care to release my medical and/or billing information to the following individual (s):

1._____Relation to Patient: _____

2._____Relation to Patient:_____

3._____Relation to Patient:_____

☐ **I do not authorize Jenkins Vision Care to release any or all information concerning my medical care to any individual.**

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected heath information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

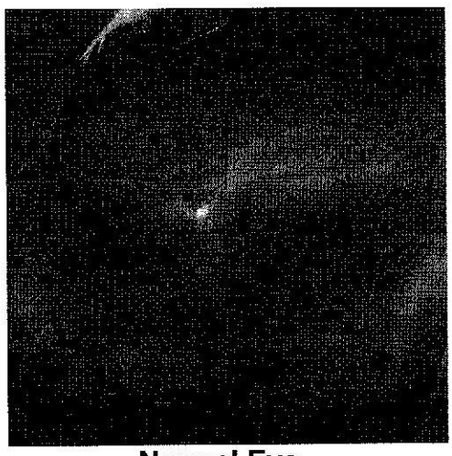
Signature: _____Date:_____

Jenkins Vision Care

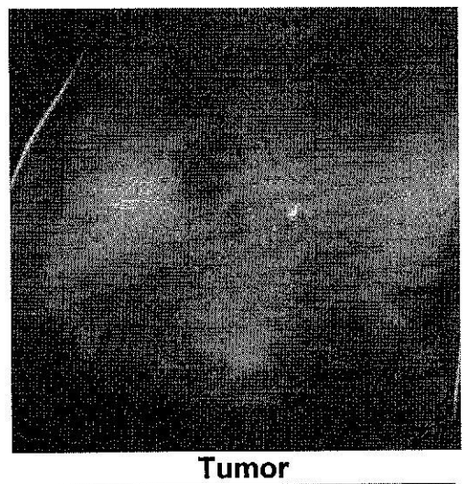
In our continued efforts to bring the most advanced technology available to our patients, Dr. Jenkins is proud to announce the availability of the Optomap Retinal Exam as an integral part of your eye exam today.

The Optomap Retinal Exam allows the doctor to evaluate macular degeneration, glaucoma, retinal holes or detachments, usually without having to dilate the eyes! These conditions can lead to partial or complete loss of vision and often develop without warning and progress with no symptoms.

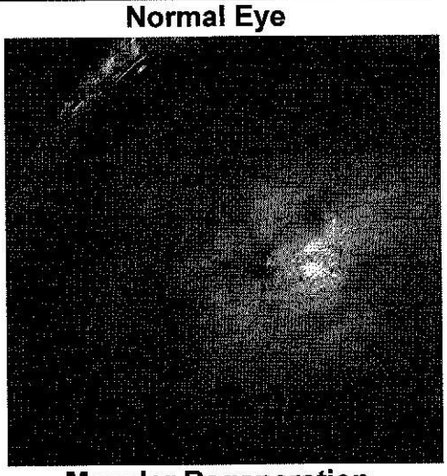
The Optomap exam is fast, easy, and comfortable, allowing an in-depth view of the retinal layers. The eye wellness scan will be reviewed with the doctor during your exam and will become a permanent record for your medical file allowing yearly comparison.



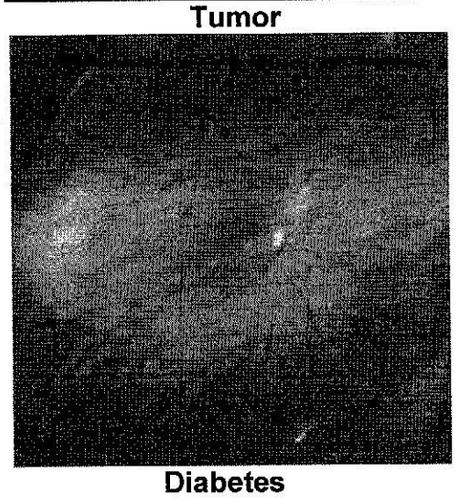
Normal Eye



Tumor



Macular Degeneration



Diabetes

Insurance typically does not cover any advanced screening technology beyond the general eye exam. Your doctor prescribes the Optomap Retinal Exam for all patients. We will be performing the Optomap Retinal Exam as an enhancement to the general eye exam for a fee of $35.00.

The benefits of the annual Optomap Exam have been described to me as a fast, comfortable in-depth view of nearly the entire retina without having the eyes dilated in most cases.

_____ I prefer to have the Optomap Retinal Exam performed.

_____ I prefer to be dilated.

Patient Signature _____ Date _____

_____