Blair M Ball, O.D.

1659 E 6th St.
Beaumont, CA 92223

Medical History Questionnaire

Name: _____ Birth Date: _____ Today's date: _____
Address_____ City_____

Phone Number: _____Work Number: _____ Cell Number: _____
E-Mail address: _____ Preferred Correspondence (Circle one): Email Text Phone Call

Name of Primary Insured:_____ Primary Insured DOB:_____
Primary Insurance ID #: _____ Primary Insured SS#: _____

Race:_____Ethnicity:_____ Preferred Language:_____

Medical History

Do you have any allergies to medications? □Yes □ No If yes, explain: _____

List any 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: _____

Check any of the following that you have had: □ Reading Difficulty □ Crossed Eyes □ Lazy Eye □ Glaucoma
□ Retinal Disease □ Cataracts □Eye Injury □ Macular Degeneration

Are you pregnant and/or nursing? □Yes □ No
Do you wear glasses? □ Yes □ No If yes, how old is your present pair of glasses? _____
Are you interested in purchasing glasses today? _____

Do you wear contact lenses? □ Yes □ No If no, would you like to try contact lenses? _____
Type of contact lenses: □ Rigid □ Soft □ Extended wear □ Other Are they comfortable? □ Yes □ No

Have you had refractive or any eye surgery □ Yes □ No If yes, what kind _____
At work: Do you perform fine or close-up work? □ Yes □ No
Do you use a computer? □ Yes □ No If yes, how many hours? _____
Are you outdoors all or part of the time? □ Yes □ No
Is safety protection a concern at work? □ Yes □ No
Do you have trouble reading signs when driving at night? □ Yes □ No
Are you bothered by the glare from: Overhead lighting □ Yes □ No
A computer screen □ Yes □ No
On coming headlight at night □Yes □ No
Are you sensitive to bright sunlight? □ Yes □ No Are you interested in purchasing sunglasses? __
What hobbies or recreational sports do you enjoy? _____

Social History

This information is kept strictly confidential. However, 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? □ Yes □ No If yes, do you have visual difficulty when driving? □ Yes □ No
If yes, please please explain_____
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 recreational drugs? □ Yes □ No If yes, type/amount/how long: _____
Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ No, I have not.

Any boxes left unchecked will be considered a "No" answer

Please turn this form over and complete Side 2

Review of Systems Do you or your family currently, or have you ever had any problems in the following areas:

System	Yes	No	Family	Not Sure
Cancer	☐	☐	☐	☐
Constitutional				
Fever, Weight Loss/Gain	☐	☐	☐	☐
Skin (Integumentary)	☐	☐	☐	☐
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/Lid	☐	☐	☐	☐
Sty or Chalazion	☐	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐	☐
Endocrine				
Thyroid/Other Glands	☐	☐	☐	☐
Psychiatric	☐	☐	☐	☐

System	Yes	No	Family	Not Sure
Ears, Nose, Mouth, Throat				
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	☐	☐	☐	☐
Brain Injury/Stroke	☐	☐	☐	☐
Gastrointestinal				
Diarrhea	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Genitourinary				
Kidney/Bladder	☐	☐	☐	☐
Bones/Joints/Muscles				
Rheumatoid Arthritis	☐	☐	☐	☐
Muscle Pain	☐	☐	☐	☐
Joint Pain	☐	☐	☐	☐
Lymphatic/Hematologic				
Anemia	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐
Allergic/Immunologic	☐	☐	☐	☐

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

_____

_____

Assignment & Release

I acknowledge that I received a copy of Family Vision Care's Notice of Privacy Practices. I authorize the release of any medial information necessary to process all claims. I also authorize the release of payment of medical benefits to my physician and understand I am responsible for non-covered services.

Signed _____ Date _____

"Thank you for completing this history form. The doctor and technicians will review your entries and ask you further questions where necessary. The doctor will then customize an examination just for you! The examination will enable us to meet your specific needs. Thank you again for choosing our office. We look forward to improving the quality of your life!"

Name: _____ Birth Date: _____ Today's date: _____
Address_____ City_____

Phone Number: _____Work Number: _____ Cell Number: _____
E-Mail address: _____ Preferred Correspondence (Circle one): Email Text Phone Call

Name of Primary Insured:_____ Primary Insured DOB:_____
Primary Insurance ID #: _____ Primary Insured SS#: _____

If all information is correct,
please initial here: _____

HIPAA ACKNOWLEDGEMENT

_____ I acknowledge that I have read and understand the HIPAA Privacy Act.

Contact Lens Agreement

_____ Contact lens wearers require additional measurements separate from a routine eye exam of glasses. These are done to ensure that your eyes are healthy, lenses fit properly, and that you are seeing as clearly as possible. This evaluation is required annually to refill your contact lens prescription. Most insurance plans do not cover this service. This evaluation must be completed within 90 days of original exam. Multiple visits may be required to complete evaluation for contacts. Additional fees may be applied if evaluation is not completed within the 90 days.

_____ The fee for this service ranges from $75.00 - $125.00 depending on the complexity of your fitting. Keratoconic patients are quoted on a case by case basis.

Urgent Medical Evaluation

_____ I acknowledge that I am responsible for my visit today. The fee for this service is $94.00 - $194.00 depending on the severity of the visit.

Optomap® Retinal Scan

_____ I acknowledge the Optomap® Retinal Scan procedure will be performed as part of my services today. The fee for this service is $29.00.

Payment Agreement

I understand that I am responsible for my portion of the fees at the time services are rendered. I understand that the benefits quoted to me are **not** a guarantee of payment by my insurance and that the final determination can only be made when the claim has been processed. I assign all medical benefits to which I am entitled including Medicare, private insurance, and other health insurance plans to Dr. Blair M Ball, O.D. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment will be considered as valid as an original. I understand that I am responsible for all charges whether or not paid by said insurance. I authorize said assignee to release all information necessary to secure payment. A 50% deposit is required on all materials ordered. Balances are due at the time materials are picked up. A $5.00 per month fee will be charged to my account for any balance not paid in full. A $30.00 fee will be charged for all dishonored checks. A $35.00 fee may be applied to accounts which do not give 24 hour notice to change or cancel their appointment time.

Signature: _____ Date: _____