Dr. David Braun, Optometrist

Medical History Questionnaire

DEMOGRAPHICS

Legal First Name________________________ Last Name________________________
Mr Mrs Ms Dr Prof Middle name____________________ Nickname____________________
Address______________________________ City____________________ State________ Zip_______
DOB:______/_____/__________ SSN# (optional) ____________________
Gender ❒ Male ❒ Female ***Marital Status*** ❒ Single ❒ Married ❒ Other
Employment Status ❒ Full Time ❒ Part Time ❒ Full Time Student ❒ Part Time Student ***Employer***__________
Contact Information ❒ Home ____________________ ❒ Work ____________________
❒ Cell ____________________ ❒ Email ____________________

Reason for visit? ______________________________

Have you ever been diagnosed with any of the following conditions?

Constitution
Y N
❒ ❒ Developmental Disabilities
❒ ❒ Fatigue Syndrome
❒ ❒ Cancer
❒ ❒ Other ______________

ENT (Ear, Nose, Throat, Mouth)
Y N
❒ ❒ Laryngitis
❒ ❒ Sinusitis
❒ ❒ Dry Mouth
❒ ❒ Hearing Loss
❒ ❒ Other ______________

Neuro
Y N
❒ ❒ Epilepsy
❒ ❒ Cerebral Palsy
❒ ❒ Multiple Sclerosis
❒ ❒ Migraine
❒ ❒ Stroke/CVA
❒ ❒ Tumor
❒ ❒ Other ______________

Psychiatric
Y N
❒ ❒ Depression
❒ ❒ Attention Deficit
❒ ❒ Anxiety Disorder
❒ ❒ Bipolar Disorder
❒ ❒ Other ______________

Cardiovascular
Y N
❒ ❒ Congestive Heart Failure
❒ ❒ Vascular Disease
❒ ❒ Heart Disease
❒ ❒ Stroke/CVA
❒ ❒ Hypertension
❒ ❒ Other ______________

Respiratory
Y N
❒ ❒ Cigarette Smoker
❒ ❒ Asthma
❒ ❒ Bronchitis
❒ ❒ Emphysema
❒ ❒ Chronic Obstruction
❒ ❒ Sleep Apnea
❒ ❒ Other ______________

Gastrointestional
Y N
❒ ❒ Colitis
❒ ❒ Crohn's
❒ ❒ Acid Reflux
❒ ❒ Ulcer
❒ ❒ Celiac Disease
❒ ❒ Other ______________

Genitourinary
Y N
❒ ❒ Benign Prostate Hypertrophy
❒ ❒ STD- herpetic/chlamydia
❒ ❒ Nursing
❒ ❒ Pregnant
❒ ❒ Chlamydia
❒ ❒ Herpes
❒ ❒ Kidney disease
❒ ❒ Prostate disease/cancer
❒ ❒ Other ______________

Musculoskeletal
Y N
❒ ❒ Osteoarthritis
❒ ❒ Fibromyalgia
❒ ❒ Muscular Dystrophy
❒ ❒ Ankylosing Spondylitis
❒ ❒ Osteoporosis
❒ ❒ Gout
❒ ❒ Arthritis
❒ ❒ Other ______________

Integumtary
Y N
❒ ❒ Eczema
❒ ❒ Herpes Zoster/Shingles
❒ ❒ Herpes Simplax/Cold Sores
❒ ❒ Psoriasis
❒ ❒ Rosacea
❒ ❒ Other ______________

Endocrine
Y N
❒ ❒ Hormonal dysfunction
❒ ❒ Type 1 Diabetes Mellitus
❒ ❒ Type 2 Diabetes Mellitus
❒ ❒ Thyroid dysfunction
❒ ❒ Other ______________

Hemotologic/Lymphatic
Y N
❒ ❒ Ulcer
❒ ❒ Hypercholesteremia
❒ ❒ Anemia
❒ ❒ Large-volume blood loss
❒ ❒ Other ______________

Allergic/Immune
Y N
❒ ❒ Sjogren's Syndrome
❒ ❒ Rheumatoid Arthritis
❒ ❒ Lupus
❒ ❒ Drug Allergies
❒ ❒ Environmental Allergies
❒ ❒ Other ______________

Medications/Allergies

Medication Allergies: ______________________________

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Other Allergies: ______________________________

____

____

Medications including dosage: ______________________________

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Have you ever been diagnosed with any of the following eye conditions?

Y	N	
❒	❒	Dry Eye
❒	❒	Injury
❒	❒	Nystagmus
❒	❒	Glaucoma
❒	❒	Retinal Detachment
❒	❒	Keratoconus
❒	❒	Surgery
❒	❒	Age-related Macular Degeneration
❒	❒	Cataract
❒	❒	Glaucoma Suspect
❒	❒	Amblyopia
❒	❒	Strabismus
❒	❒	Inflammatory Disorder
❒	❒	Patching
❒	❒	Retinal Hole
❒	❒	Retinal Degeneration
❒	❒	Other ____________

Family Medical History

F	M	Bro	Sis	S	D	Y	N	
❒	❒	❒	❒	❒	❒	❒	❒	Cancer
❒	❒	❒	❒	❒	❒	❒	❒	Diabetes mellitus in 1st degree relative
❒	❒	❒	❒	❒	❒	❒	❒	Diabetes mellitus type 1
❒	❒	❒	❒	❒	❒	❒	❒	Diabetes mellitus type 2
❒	❒	❒	❒	❒	❒	❒	❒	Hypertension
❒	❒	❒	❒	❒	❒	❒	❒	Hyperthyroidism
❒	❒	❒	❒	❒	❒	❒	❒	Hypothyroidism

***Father, Mother, Brother, Sister, Son or Daughter**

Family Eye Conditions

F	M	Bro	Sis	S	D	Y	N	
❒	❒	❒	❒	❒	❒	❒	❒	Cataract
❒	❒	❒	❒	❒	❒	❒	❒	Degenerative Disorder
❒	❒	❒	❒	❒	❒	❒	❒	Glaucoma

***Father, Mother, Brother, Sister, Son or Daughter**

Social History

Do you drink alcohol? ❒ Yes ❒ No

If yes, amount?______________________________

Do you currently smoke? ❒ Yes ❒ No

If yes, amount?

Contact Lens History

Type ❒ Soft ❒ RGP ❒ Hybrid ❒ Unsure

Brand: ______________________________

Prescription:

Right ______________________________

Left______________________________

HIPPA Notice and Authorized Signature

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment for benefits/services rendered to Dr. Braun & Associates and /or Original Eyewear. I understand that I am responsible for fees that are not paid by my insurance company.

PATIENT'S "SIGNATURE ON FILE"______________________________ DATE____________________

Original Eyewear
Dr. David Braun

Office Policy Regarding Payments and HIPPA

Payment is ***expected*** at the time of service. You are ultimately responsible for the balance of your account for any professional services rendered and materials dispensed by Dr. Braun and Original Eyewear.

It is the patient's responsibility to inform our office of any insurance prior to your exam. As a courtesy, we will file insurance claims for you, and payment will be deferred for those plans we participate with. We will inform you if we accept assignment on your insurance.

Our office cannot guarantee that your insurance company will pay for services billed. We will make every attempt to verify coverage. However, if your insurance claim is denied, or if you insurance company does not pay within 90 days, you are responsible for the full amount of your bill. If you decide to appeal your insurance company's decision, our office will provide you with any necessary information to assist you in getting re-imbursed directly from your insurance company.

Our office will send your information to a collection agency in the event of non-payment. If your account is sent to a collection agency, you will be responsible for all collection costs.

Vision plans vs. medical plans. We can only submit a claim to your vision plan if you have a normal healthy eye exam. If during your exam, it is revealed that you have a medical condition or problem with your eyes, we are required to perform a medical eye exam and must submit the claim to your medical insurance plan. This is subject to the medical insurance plan's copays and deductibles.

All products sold at Original Eyewear are custom made and therefore cannot be returned or refunded, including non-prescription sunglasses, contact lenses, and frame only purchases.

An evaluation for contact lenses is not included with routine eye exam. More time is needed to properly evaluate the eyes and contact lenses which may include multiple follow up visits over several weeks. Additional charges will apply if you would like a new or renewed contact lens prescription.

By signing this form, I agree to all of the above information. I authorize Dr. David Braun to receive insurance payments on my behalf for services rendered or materials dispensed. I authorize the release of the necessary information to determine the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

By signing this form I have been made aware of Dr. David Braun & Original Eyewear's HIPPA policy and procedures.

Signed:____Date______________________
(Patient or Guarantor)