

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of birth _____ Date of last eye exam _____

List any medications you currently take (prescription and over-the-counter):

Do you have a allergies to any medications? YES NO

If YES, list the medications:

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

List any surgeries you have had (cataract, tonsillectomy, appendectomy):

Do you *currently* have any problems in the following areas? If "YES", please provide information

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision(halos)			
Less 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			
Infection of eye or lid (blepharitis, style)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			

CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple, sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY

M-mother F-father S-sibling GP-grandparent

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: _____

Education (high school, vocational school, college degree): _____

Marital Status (married, divorced, single, widowed): _____

Living Arrangements: _____

Do you drive? YES NO

Do you have visual difficulty when driving? YES NO

Do you have problems with night vision? YES NO

Have you ever tried to wear contact lenses? YES NO

Do you currently wear contact lenses? YES NO

If YES, how long have you worn contact lenses? _____

Do you currently wear glasses? YES NO

If YES, how long have you had the current prescription? _____

Do you drink alcohol? YES NO If YES: occasional 1 per day 2-3 /day 4+/day

Do you smoke? YES NO If Yes: occasional 1/2 pack/day 1 pack/day 1+pack

Have you ever had a blood transfusion? YES NO

History Reviewed No Changes Additions as noted above.

Physician's Signature: _____ Date: _____



SOUTH TEXAS RETINA CONSULTANTS, L.L.P.

CHARLES H. CAMPBELL, M.D., F.A.C.S., F.I.C.S.

Main Office

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Fax 361-993-9184

McAllen Eye Center

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McAllen, TX
78503

956-682-2463
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Satellite Offices

Alice

411 Flournoy Rd.
(Encino Bldg.), Ste. 204
Alice, TX 78332

Aranas Pass

423 West Cleveland
Aranas Pass, TX 78336

Beeville

1811 Northwest Frontage Rd.
Hwy 181
Beeville, TX 78102

Brownsville

9 North Park Plaza
Brownsville, TX 78520

Eagle Pass

708 S. Bibb
Eagle Pass, TX 78852

Kingsville

1126 South 14th St., #A
Kingsville, TX 78363

Patient Name: _____

DATE: _____

Financial Policy Statement

It is STRC's financial policy to bill your insurance company **as a courtesy** to you for all major services (those in excess of \$250.00), although ***you do remain responsible for the entire bill.*** Once the insurance company is billed, we will set aside the estimated portion due from the insurance company for 60 days. We do require that the patient's portion be paid at the time of service. If your insurance company does not remit payment within 60 days, the balance will be due in full from you. If you should receive any payments from your insurance company for services still due to us, please remit those payments to us immediately. Similarly, if we receive any payment in excess of the estimated balance due from your insurance company, we will promptly refund the credit amount to you. **For all services less than \$250.00, payment will be expected at the time of service.**

You are responsible for knowing the status of your insurance coverage. Please inform us of any changes when you check-in. If there is no insurance coverage, you will be responsible for the whole amount of your bill.

If you have no insurance coverage, payment in full will be expected at the time of service. Any other type of payment arrangement must be established through the Credit Manager in our insurance department.

For Medicaid and Workers Compensation claims, we will bill all services directly. No payment will be expected from the patient unless the services are denied for reasons of expired Medicaid eligibility or denied workers compensation acceptance. Please, note that **proof of Medicaid eligibility is required at the time of service.**

For our HMO / PPO covered patients, **co-pays are due at the time of service.** If your insurance plan requires a referral or authorization, you must present this at the time of service along with your insurance ID card. In addition, **payment for any non-covered services will be due at the time of service.**

For our Medicare patients, STRC is a participating provider; therefore, all covered services will be billed to Medicare for you. You are to pay only the applicable patient co-insurance (20%) and/or deductible.

I have read and understand the financial policies of South Texas Retina Consultants. I understand that I am responsible for knowing the status of my insurance coverage. If coverage is denied from my insurance company, Workers Compensation carrier, Medicare, Medicaid, or any other agency through which I have applied for assistance, I understand that I become responsible for payment in full of all incurred charges for services rendered.

Signature of Patient/Responsible Party

Date

STRC Representative