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

PATIENT INFORMATION: **PLEASE PRINT**	
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#: Cell PH#:	Preferred Pharmacy: Location:
**Ethnicity: Hispanic/Not Hispanic/REFUSED to specify **Race: American Indian/Asian/Hawaiian or Pacific Islander Black or African American/White/Hispanic/Other REFUSED to Specify **Language: English/Spanish/Russian/Indian/Other	Name of Employer: Occupation:
RESPONSIBLE/BILLING PARTY:	**EMERGENCY CONTACT INFO:**
Name:	Last:
Relationship to patient:	First:
Date of Birth ____/____/_____ (MM/DD/YYYY)	Relationship to Patient:
*BILLING Address:	Physical Address:
City: State: Zip:	City: State: Zip:
Home Ph#: Cell Ph#:	Home Ph#: Cell Ph#:
INSURANCE INFO: (present card at check in – this will be scanned into your file)	
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.**

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 _____