



FIRST EYE CARE KILLEEN

Medical History Questionnaire – Required Annually for All Eye Examinations

Primary Care Doctor (Family Doctor, Pediatrician, Internist) _____

Other Specialist Doctors: _____

Previous Eye Doctor: _____ Last Eye Exam Date: _____

Current medications that you take: (Name, Dosage and Frequency)

- You may bring a separate _____
sheet to scan if available _____

Eye drops that you use: (Name, Dosage and Frequency)

- Rx and OTC drops _____

Allergies to any medicines/drugs? None Please List: _____

Social History

Women only: Are you currently pregnant or breastfeeding? Yes No

Do you smoke? Yes No Quit If yes, _____ packs per day for _____ years

If you quit, _____ packs per day for _____ years ending in what year? _____

Do you drink alcohol? Yes No Occasionally Rarely If yes, _____ drinks per week for _____ years

General Health History (*check all that apply, and write what year the condition was diagnosed*)

- | | | | | | |
|--|-------------|--|-------------|---|-------------|
| <input type="checkbox"/> Diabetes | since _____ | <input type="checkbox"/> Lupus | since _____ | <input type="checkbox"/> HIV | since _____ |
| <input type="checkbox"/> High Cholesterol | since _____ | <input type="checkbox"/> Thyroid | since _____ | <input type="checkbox"/> Head trauma | when? _____ |
| <input type="checkbox"/> High Blood Pressure | since _____ | <input type="checkbox"/> Heart Disease | since _____ | <input type="checkbox"/> Massive blood loss | when? _____ |
| <input type="checkbox"/> Arthritis | since _____ | <input type="checkbox"/> Headaches | since _____ | <input type="checkbox"/> Seizures | since _____ |
| <input type="checkbox"/> Allergies | since _____ | <input type="checkbox"/> Migraines | since _____ | <input type="checkbox"/> Cancer | when? _____ |
| <input type="checkbox"/> Asthma | since _____ | <input type="checkbox"/> Stroke | when? _____ | <input type="checkbox"/> Stomach Problems | since _____ |
| <input type="checkbox"/> Lung Disease | since _____ | <input type="checkbox"/> Heart Attack | when? _____ | <input type="checkbox"/> Liver Disease | since _____ |

Past Surgeries? (*what and when*) _____



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Family Medical History (*check all that apply, and write who is affected, i.e. mother, father, brother, sister, grandmother*)

- ◇ Diabetes Who? _____ ◇ Stroke Who? _____
- ◇ High Blood Pressure Who? _____ ◇ Heart Disease Who? _____
- ◇ High Cholesterol Who? _____ ◇ Cancer Who? _____

Ocular History (*check all that apply, and write what year the condition was diagnosed*)

- ◇ Glaucoma since _____ ◇ Amblyopia (lazy eye) since _____ ◇ Macular Degeneration since _____
- ◇ Diabetic Retinopathy since _____ ◇ Strabismus (eye turn) since _____ ◇ Herpes Simplex/Zoster since _____
- ◇ Cataracts since _____ ◇ Double Vision since _____ ◇ Corneal Foreign Body /Abrasion when? _____
- ◇ Keratoconus since _____ ◇ Retinal Tear/Detachment when? _____ ◇ Recurrent Corneal Erosions since _____
- ◇ Dry Eyes since _____ ◇ Eye Injury when? _____ ◇ Ocular Allergies since _____

Ocular Family History (*check all that apply, and write which family member is affected*)

- ◇ Glaucoma who? _____ ◇ Macular Degeneration who? _____
- ◇ Cataracts who? _____ ◇ Corneal Disease who? _____
- ◇ Amblyopia (lazy eye) who? _____ ◇ Retinal Disease who? _____
- ◇ Strabismus (eye turn) who? _____ ◇ Blindness who? _____

Previous Eye Surgeries (*check all that apply, and write the year of the surgery*)

- ◇ none ◇ PRK when? _____ ◇ cataract when? _____ ◇ cornea transplant when? _____
- ◇ LASIK when? _____ ◇ RK when? _____ ◇ eye muscle when? _____ ◇ retinal surgery when? _____

Contact Lens History (*If you are a contact lens wearer, check one or more from each vertical box*)

◇ never worn	◇ never sleep in lenses	◇ no problems	◇ problems often
◇ wear daily	◇ sleep in lenses occasionally	◇ comfort problems	◇ problems occasionally
◇ wear occasionally	◇ sleep in lenses nightly	◇ vision problems	◇ problems rarely

What contact lens solution do you use? ◇ Optifree ◇ Clear Care ◇ Renu ◇ Aquify ◇ Complete ◇ Store Brand



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Review of Body Systems

Body System

Please circle any of the following symptoms or problems that are CURRENTLY afflicting you.

Constitutional	None	Chills Weakness	Fatigue Weight Gain	Fever Weight Loss	Loss of Appetite Headaches	Night Sweats
Eyes	None Tearing Loss of Side Vision	Blurry Vision Light Sensitivity Glare	Discharge Flashes of Light Itchiness	Double Vision Floaters Loss of Vision	Droopy Eyelid Foreign Body Sensation Pain	Redness Fluctuating Vision Color Vision Changes
Ears, Nose, Throat	None	Dry Mouth Mouth Ulcers Smell Disturbance	Earaches Nasal Discharge Sore Throat	Hearing Loss Nose Bleeds Ringing Ears	Infection Pain Dizziness	Mass Sinus Congestion
Cardiovascular	None	Chest Pain Palpitations	Heart Failure Rheumatic Fever	Heart Murmur Slow Heart Rate	High Blood Pressure Fast Heart Rate	Irregular Heart Beat
Respiratory	None	Asthma Wheezing	Bronchitis Spitting Up Blood	Shortness of Breath Tuberculosis	Chronic Cough Pneumonia	Emphysema
Gastrointestinal	None	Abdominal Pain Vomiting Heartburn	Appetite Change Blood in Vomit Hepatitis	Difficulty Swallowing Stomach Ulcers Nausea	Diarrhea Blood in Stool Jaundice	Constipation Hemorrhoids Colon Polyps
Genitourinary	None	Discharge Kidney Stones	Blood in Urine Pain	Frequent Urination Infections	Difficulty Urinating Impotence	Painful Urination Sexual Difficulties
Muscular/Skeletal	None	Arthritis Muscle Aches	Fractures Muscle Cramps	Joint Pain Gout	Low Back Pain Sprains	Swollen Joints
Skin	None	Rashes Itching	Dermatitis Masses	Psoriasis Pigmented Lesions	Eczema Loss of Hair	Hives Skin Cancer
Neurological	None	Weakness Memory Loss	Headache Paralysis	Numbness Coordination Problems	Tingling Stroke Deficits	Seizures Balance Problems
Psychiatric	None	Depression	Mood Swings	Hallucinations	Sleep Disturbances	Anxiety
Endocrine	None	Diabetes Cold Intolerance	Excessive Hunger Low Blood Sugar	Excessive Thirst Hypo Thyroid	Excessive Urination Hyper Thyroid	Heat Intolerance
Blood/Lymphatic	None	Anemia	Easy Bleeding	Easy Bruising	Swollen Glands	Clotting Problems
Allergy/Immunologic	None	Itching	Hives	Eczema	Rashes	Hay Fever



FIRST EYE CARE KILLEEN

Thomas A. Lucas Jr., O.D.

Karen M. Summers, O.D.

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Financial Agreement – Signature Required Annually

Signing this paper IS REQUIRED by Killeen Eye Associates, P.A., dba First Eye Care Killeen, if you wish to have third-party insurance claims filed on your behalf. If left unsigned, you will be responsible for full payment of services rendered at the time of service at our usual and customary fee levels.

I understand that depending on the nature of my visit and types of services performed, my medical insurance and/or my routine vision plan may be filed, with all applicable co-pays, co-insurances, and deductibles due today.

I understand that the nature of my eye complaint, ocular history and ultimate diagnosis are the determining factors for deciding whether my medical insurance or my vision plan is the appropriate third party to be billed. I also understand that in the absence of a medical complaint, my vision plan exam coverage provides for routine services only (determination of refractive error) and for the screening detection of medical eye problems. If medical eye problems are detected, further evaluation and management is only covered by my medical insurance; and all deductibles, co-payments, and co-insurance amounts will apply.

I acknowledge that First Eye Care Killeen will make only reasonable efforts to process my claim for services and/or products rendered.

I request that payment from my third-party payor be made to First Eye Care Killeen. for any services or products furnished to me by this provider.

I authorize First Eye Care Killeen to release any personal or medical information to any medical insurance, vision plan company or its agents that is necessary for determining my benefits or collecting payment from my third party payor.

I understand that deductibles, co-payments, and co-insurance must be collected from me by First Eye Care Killeen as required by my insurance company at the time services are rendered.

I understand that if for ANY REASON payment for provided services and/or products is denied to First Eye Care Killeen by my third-party insurance, I am responsible for paying for these provided services and/or products. I understand that in this occurrence, I will be billed for the services and/or products that were denied by insurance and payment will be expected within 30 days of receipt of this bill.

I understand that payment may be made to First Eye Care Killeen with cash, Mastercard, Visa, American Express, Discover, personal check, Care Credit, or flex account card. No temporary checks will be accepted. Out-of-state checks will be accepted only with prior management approval.

I understand that writing a personal check with insufficient funds is check fraud, and that all matters involving check fraud will be referred to the Bell County District Attorney's office for review and collection. A returned check fee of \$30.00 will be assessed to me.

SIGNATURE: _____ DATE: ____ / ____ / _____



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Notice Of Privacy Practices Acknowledgement

The full Notices of Privacy Practices of Killeen Eye Associates, P.A. is available by request from our check-in desk, and is also available online at www.firsteyecarekilleen.com.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understood the Notice of Privacy Practices of Killeen Eye Associates, P.A., which contain a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

NAME (please print): _____

SIGNATURE: _____ DATE: ____ / ____ / _____