





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

2102 South W.S. Young Dr.  
Killeen, TX 76543  
Phone: 254-690-4733  
Fax: 254-690-6728

## 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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_