

TODAY'S DATE _____

WELCOME TO THE OFFICE OF DR. WILLIAM J. MATEIK, DOCTOR OF OPTOMETRY

Name _____ Date of Birth _____ Sex: M F
Address _____
City _____ State _____ Zip _____
Phone (Home) _____ Phone (Cell) _____ Phone (Work) _____
Name of Employer _____ Occupation _____
Medical Insurance _____ Exam Co-Pay _____
Vision Insurance _____
Subscriber _____ Subscriber ID or SS# _____
Patient's Relation to Subscriber: Self Spouse Child Former-Spouse Other _____
Subscriber's Date of Birth _____

Assignment and Release

I authorize payment of benefits directly to **Dr. W. J. Mateik** for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.

I understand that some services may require approval of my primary care physician for coverage and that, if I do not obtain that approval, I am financially liable for the services.

I understand that my insurance carrier may not cover some services and products and benefits information does not constitute approval of payment. Deductibles & Fees not paid by my insurance carrier will be my responsibility.

I acknowledge that I received a copy of **Dr. W. J. Mateik's "NOTICE OF PRIVACY ACT, HIPAA"** policy.

Signature _____ Date _____

Medical History Questionnaire

FAMILY/PERSONAL HISTORY

What problems are you currently having with your eyes? (Circle all that apply)

- | | | |
|------------------------|--------------------------------------|-------------------------|
| Blurred Vision | Redness | Mucous Discharge |
| Distorted Vision/Halos | Burning | Foreign Body Sensation |
| Loss of Side Vision | Itching | Sandy or Gritty Feeling |
| Loss of Central Vision | Dryness | Chronic Lid Infection |
| Double Vision | Tired Eyes | Glare/light Sensitivity |
| Flashes/Floating Spots | Watering Excessively | Eye Pain or Soreness |
| Crusting on eyelashes | Having Problems with Contact Lenses? | |

Do you have any of the following eye conditions? (Circle all that apply)

- | | | |
|------------|----------------------|----------------------|
| Blindness | Diabetic Eye Disease | Macular Degeneration |
| Cross-eyes | Retinal Detachment | Glaucoma |
| Cataracts | Lazy Eye | Retinal Disease |

Do any blood relatives have any of the following eye or medical conditions? (Circle all that apply)

- | | | |
|-------------|----------------------|----------------------|
| Blindness | Glaucoma | Diabetic Eye Disease |
| Cataracts | Macular Degeneration | Amblyopia (Lazy Eye) |
| Crossed Eye | Diabetes | High Blood Pressure |
| Cancer | Thyroid Disease | Retinal Disease |

Retinal Detachment
Other: _____

REVIEW OF SYSTEMS

Do you have any of the following medical conditions? (Circle all that apply)

- | | | |
|--------------------|-----------------------|--------------------------|
| Headaches | Allergies/Hay Fever | Asthma |
| Diabetes | Migraine | Sinus Congestion |
| Chronic Bronchitis | Heart/Chest Pain | Bleeding Disorder |
| Runny Nose | Emphysema | High Blood Pressure |
| Stroke/Seizures | Cancer | Fever, Weight Loss/ Gain |
| Chronic Cough | Arthritis | High Cholesterol |
| Thyroid Disease | Diarrhea/Constipation | Dry Throat/ Mouth |
| Fibromyalgia | Psoriasis or Rosacea | Kidney/Bldder Disease |
| Lupus | Depression | Heart Disease |
- Other: _____

SOCIAL HISTORY

Please answer the following: (Circle Answer)

- | | | | | | |
|--|-----------|---------|--------------------|------------|----------------------------|
| Do you drive? | YES | NO | | | |
| Do you consume alcohol? | YES | NO | | | |
| Do you use tobacco products? | YES | NO | | | |
| Are you a carrier of or infected with: | Hepatitis | HIV | Gonorrhea/Syphilis | None | |
| Marital / Living Status: | Single | Married | Widowed | Live Alone | Live with Family or Friend |

MEDICAL HISTORY

Please list all medications you are taking: _____

When was your last physical exam? _____

Who is your primary care physician? _____

Are you Pregnant? YES NO

Are you allergic to any medications? YES NO

If Yes, Please List _____

List all EYE surgeries or injuries you have had in the past 10 years

Do you wear GLASSES? YES NO

Do you wear CONTACT LENSES? YES NO

FOR OFFICE USE

Doctor's Signature _____

Date _____