



Medical Questionnaire

Name: Mr. Ms. Mrs. Dr. _____ Date of birth: _____
Last First Middle initial

Chief medical reason for this visit: _____

Who referred you here? _____
Name Address Tel no

Who is your primary care physician? _____
Name Address Tel no

List any eye conditions you have: _____

List any eye surgeries you have had (including laser surgeries): _____

Do you wear contact lenses? _____ Hard Soft Bifocal Toric Brand: _____

General medical history (check all that apply):

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Sickle cell |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lupus | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraine | _____ |
| <input type="checkbox"/> Environmental allergies/ hayfever | <input type="checkbox"/> Multiple sclerosis | _____ |
| <input type="checkbox"/> Pulmonary disease | <input type="checkbox"/> HIV | |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Chronic hepatitis | |

Major surgeries: _____

Please list the medications you are taking (including eye medications):

Name	Dosage	Frequency	Name	Dosage	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies to medications: _____

Do you smoke? _____ # of packs per day: _____ # of years: _____

List conditions that run in your family:

	Macular degeneration	Cataract	Glaucoma	Glaucoma suspect	Kerato-conus	Retinal detachment	Blindness
Paternal grandmother							
Paternal grandfather							
Maternal grandmother							
Maternal grandfather							
Mother							
Father							
Sister(s)							
Brother(s)							
Other							

	Cancer	Stroke	Diabetes	Heart Disease	High blood pressure	Thyroid disease	Other
Paternal grandmother							
Paternal grandfather							
Maternal grandmother							
Maternal grandfather							
Mother							
Father							
Sister(s)							
Brother(s)							
Other							

Are you *currently* experiencing:

	Yes	No	Explanation of problem
Constitutional symptoms: (Fever, weight change, sleep disturbances)	_____	_____	_____
Ears, nose, mouth, and throat: (Deafness, ear infections, mouth lesions, sinusitis, vertigo)	_____	_____	_____
Cardiovascular: (Chest pain, palpitations)	_____	_____	_____
Respiratory: (Chronic cough, shortness of breath, wheezing)	_____	_____	_____
Gastrointestinal: (Acid reflux, constipation, diarrhea, jaundice, vomiting)	_____	_____	_____
Musculoskeletal: (Arthritis, muscle pain, back problems)	_____	_____	_____
Genitourinary: (Kidney stones, urinary frequency/ urgency)	_____	_____	_____
Skin: (Rashes, ulcers)	_____	_____	_____
Neurological: (Seizures, head injury, headache, paralysis, fainting episodes)	_____	_____	_____
Endocrine: (Cold intolerance, heat intolerance)	_____	_____	_____
Hematologic, Lymphatic: (Anemia, excessive bleeding, blood clots, easy bruisability)	_____	_____	_____
Psychiatric: (Anxiety, depression, mania, psychosis)	_____	_____	_____

Patient's signature: _____

Date: _____

Reviewed by M.D.: _____

Date: _____

Appointment Information

Doctor's Name	Provider #	Appt Date	Appt Time	Appt #
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REGISTRATION FORM

Instructions: Fill in the blanks. Replace any wrong or outdated information by crossing it out and noting the change.

Patient Information							
First Name, MI		Last Name		Sex	Marital	DOB	SSN
Address				City		State	Zip
Home Phone	Home Fax#	Cell Phone	Email Address		NYH Chart #	IDX MRN	
Mother's Name	Mother's DOB (Peds Pts Only)	Father's Name		Father's DOB (Peds Pts Only)		Patient's Birthplace	
Employer Name	Employer Address		City, State		Zip	Work Phone	Work Fax#
Reason for visit							
PERSON TO CONTACT IN CASE OF AN EMERGENCY							
Emergency Contact's Name			Relationship		Home Phone	Work Phone	

Your Physicians				
Referring Physician's Name				
Address		City	State	Phone
Primary Care Physician Name				
Address		City	State	Phone
OB/GYN Name (female patients)				
Address		City	State	Phone

Your Insurance Information					
PRIMARY Insurance Name		Certificate/Policy #		Group #	Phone
Address		City		State	Zip
Insured's Name		Relation to Insured	Insured's DOB	Effective Date	Expiration Date
SECONDARY Insurance Name		Certificate/Policy #		Group #	Phone
Address		City		State	Zip
Insured's Name		Relation to Insured	Insured's DOB	Effective Date	Expiration Date

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize and direct Weill Cornell Physicians, having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to Weill Cornell Physicians sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan.

{ } (Medicare) I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the SS Administration and HCFA or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services or authorize such physician to submit a claim to Medicare for payment to me.

Signature of Patient or Authorized Guardian

Date