Medical History Questionnaire

Please Present all Insurance or
Discount cards at time of service

Date____/____/____

Mr. Mrs. Ms. Dr. Patient Name: _____
Responsible Party: _____ Referred By: _____
Street: _____ Home Phone: _____
City: _____ Cell Phone: _____
State: _____ Zip: _____ E-Mail: _____ Work Phone: _____
Birth Date: _____/_____/_____ Age_____ Social Security #: _____/_____/_____

Name of Medical Doctor: _____ Last Medical Exam: ___/___/____
Last Eye Exam: ___/___/____ From: _____ Have you been seen in our office before? _____

Occupation: _____ Employed By: _____
Vision Insurance Co.: _____ ID# _____
Group#_____
Medical Insurance Co.: _____ ID# _____
Group#_____

Medical History

Do you have any allergies to medications? No Yes If yes, please explain
_____
_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):
_____
_____

List all major injuries, surgeries and/or hospitalizations you have had:
_____
_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:
_____
_____

Are you pregnant and/or nursing? No Yes
Do you wear glasses? No Yes If yes, how old is your present pair of glasses? _____
Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _____
Type of contact lenses: Gas Permeable Yearly Soft Disposables Are they comfortable? No Yes

Are you considering refractive surgery / LASIK at some time in the future? No Yes

Family History

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

Disease/ Condition	No	Yes	?	Relationship to Patient
Blindness				
Cataract				
Crossed Eyes				
Glaucoma				
Macular Degeneration				
Retinal Detachment/Disease				
Arthritis				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Lupus				
Thyroid Disease				
Other				

Review of Systems

Do you currently, or have you ever had any problems in the following areas?

System	No	Yes	?
Constitutional			
Fever, Weight Loss/ Gain			
Integumentary (Skin)			
Neurological			Headaches
Migraines			
Seizures			
Eyes			
Loss of Vision			
Blurred Vision			
Distorted Vision/Halos			
Loss of Side Vision			
Double Vision			
Dryness			
Mucous Discharge			
Redness			
Sandy or Gritty Feeling			
Itching			

Burning
Foreign Body Sensation
Excess Tearing/Watering
Glare/Light Sensitivity
Eye Pain or Soreness
Chronic Infection or Eye or Lid
Sties or Chalazion
Flashes/Floaters in Vision
Tired Eyes

Endocrine

Thyroid/Other Glands

No Yes ?

Ears, Nose, Mouth, Throat

Allergies / Hay Fever
Sinus Congestion
Runny Nose
Post-Nasal Drip
Chronic Cough
Dry Throat/Mouth

Respiratory

Asthma
Chronic Bronchitis
Emphysema

Vascular/Cardiovascular

Diabetes
Heart Pain
High Blood Pressure
Vascular Disease

Gastrointestinal

Diarrhea
Constipation

Bones/Joints/Muscles

Rheumatoid Arthritis
Muscle Pain
Joint Pain

Lymphatic, Hematological

Anemia
Bleeding Problems

Allergic/Immunologic

Psychiatric

Social History

This portion is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes If yes, please describe:

_____

Do you use tobacco products? No Yes If yes, type/ amount / how long:

_____

Do you drink alcohol? No Yes If yes, type / amount / how long: _____

Do you use illegal drugs? No Yes If yes, type / amount / how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

PAYMENT EXPECTED ON DAY OF VISIT

_____ _____

Patient / Guardian Signature Date