Medical History Questionnaire Today's Date _____

Name: _____ Birth date____/____/_____

Address: (street) _____ Home phone: _____

(city) _____ Cell phone: _____

(state) _____ (zip) _____ Work phone: _____

Sex : (circle one) Male Female Marital Status: (circle one) S M D W

Social Security Number: _____ Full-time student: Yes / No Grade in school ___

Employer: _____ Occupation: _____

Vision Insurance: _____ Medical Insurance: _____

Subscriber's name: _____ Does your insurance require a referral? Yes / No

Spouse: _____ Legal guardian: _____

Medical History

Last medical exam: _____ Last eye exam: _____

Do you have any allergies to medications or latex? Yes / No List any allergies_____

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

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

_____

Circle any of the following you have had: eye injury lazy eye drooping eyelid prominent eyes

glaucoma retinal disease cataracts other eye problem:_____

Do you wear glasses? Yes / No If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? Yes / No If yes, How old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended wear Daily Are they comfortable?___

Do you need safety glasses for work? Yes / No

Have you ever had your eyes dilated? Yes / No If yes, did you have a reaction to the drops? Yes / No

Are you pregnant and /or nursing? Yes / No

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

Social History This information is strictly confidential. You may discuss this portion directly with the doctor if you prefer.

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

Do you drink alcohol? Yes / No If yes, how many drinks per week? _____

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

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None of these

Family History

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

Diseases/Conditions	No	Yes	Not sure	Relationship to you
Blindness	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Crossed eyes	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular degeneration	☐	☐	☐	_____
Retinal disease/detachment	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
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?*

	No	Yes	Not sure
CONSTITUTIONAL			
Fever, weight loss/gain	☐	☐	☐
INTEGUMENTARY (skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of vision	☐	☐	☐
Blurred distance vision	☐	☐	☐
Blurred near vision	☐	☐	☐
Distorted vision/haloes	☐	☐	☐
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 of eye	☐	☐	☐
Sty or chalazion	☐	☐	☐
Flashes/floaters in vision	☐	☐	☐
Tired eyes	☐	☐	☐
Computer vision problems	☐	☐	☐
ENDOCRINE			
Thyroid/other glands	☐	☐	☐

	No	Yes	Not sure
EARS, NOSE, MOUTH, THROAT			
Allergies, hay fever	☐	☐	☐
Sinus congestion	☐	☐	☐
Runny nose	☐	☐	☐
Post-nasal drip	☐	☐	☐
Chronic cough	☐	☐	☐
Dry mouth/throat	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart pain	☐	☐	☐
High blood pressure	☐	☐	☐
Vascular disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/kidney/bladder	☐	☐	☐
BONES/JOINTS/MUSCLES			
Rheumatoid arthritis	☐	☐	☐
Muscle pain	☐	☐	☐
Joint pain	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding problems	☐	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you have another condition that is not listed, please explain: _____

Emily Eye Care, LLC
Lily Yeh, O.D. and Austin White, O.D.
139 Hazard Avenue, Building 1, Unit 1, Enfield, CT 06082
Phone: (860) 749-1233 Fax: (860) 749-4613

Name(s):_____

Street/PO Box:_____

City/Town:_____ **State:**_____ **Zip Code:**_____

Date(s) of Birth:_____ **Social Security Number:**_____

Please update your contact information and indicate which method you prefer:

Cell:_____ **May we call?** Yes / No **May we text?** Yes / No

Home:_____ **May we call?** Yes / No

Work:_____Ext._____ **May we call?** Yes / No

Email Address:_____

***We only use your contact information to notify you when your glasses and/or contacts are in, if you are due for an appointment, and to confirm any upcoming appointments. We do NOT sell your information.

Please provide us with your primary care physician's information:

Primary care physician:_____ Phone:_____

Practice name:_____ Fax:_____

If there are any specialists you see who should receive a copy of any reports written by the doctor, please give us their contact information.

Specialist/practice name:_____ Phone:_____

Specialty:_____ Fax:_____

How did you find out about our office?_____

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ACKNOWLEDGEMENT OF RECEIPT OF OUR *NOTICE OF PRIVACY PRACTICE*

Name(s):_____ Phone Number:_____

Address:_____

Signing this document signifies that you have received a copy of our *Notice of Privacy Practices.*

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from the office of Emily Eye Care, LLC.

_____ _____

Signature Date

If signing this as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

_____ _____ _____

Relationship to Patient Print Name Source of Authority

I understand that I am responsible for providing Emily Eye Care with my current insurance information and that I am responsible for any remaining balance for services or materials not covered by my insurance. If any medical testing is done by the doctor, it will be billed to my medical insurance and may be applied to my deductible for which I will be responsible.

_____ _____

Signature Date