Medical History Questionnaire

Name ____ Today's Date:______________

Address ____

City/State/Zip ____

Birth Date ______________________ Age: ______________ Occupation:______________

Phone (Home) ______________________ Cell: ______________

Please check [✔] the preferred method of confirmation: [ ] Phone [ ] Text [ ] Email: ____________________

Last Eye Exam (Approx): ______________ Eye Dr. Name:________________________

Vision Insurance: ____________________ Medical Insurance: ____________________

How did you hear about our office? ____

Medical History

Do you have any allergies to medications? (No) (Yes) If yes, explain:____________________

____

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

____

____

____

____

When was your last physical? (Approx.) ____

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

____

Have you ever had eye infections / Injury? Please explain: ______________________________

____

Are you pregnant and/or nursing? (No) (Yes)

Do you wear glasses? (No) (Yes) If yes, how old are they?______________

Do you wear sunglasses? (No) (Yes) If yes, how old are they?______________

Do you wear contact lenses? (No) (Yes) If yes, how old is your current pair of lenses?______________

If never worn contacts, are you interested in trying them? (No) (Yes)

Type of contact lenses: (**Rigid**) **(Soft)** **(Extended Wear)** **(Other)** Are they comfortable? (Yes) (No)

Check what you would like to achieve from your contacts: [ ] Better vision [ ] Comfort [ ] Less Dry [ ] Less solution use

Family History

Please **indicate** any personal OR family history (parents, grandparents, siblings, children, living or deceased) for the following conditions: *** *key:* **S = Self M = Mother F = Father G = Grandparent SS = Sister B = Brother**

______________Blindness

______________Cataract

______________Crossed Eyes / Lazy Eyes

______________Glaucoma

______________Macular Degeneration

______________Retinal Detachment/Disease

______________Arthritis

______________Cancer

______________Diabetes

______________Heart Disease

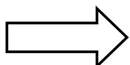
______________High Blood Pressure

______________Kidney Disease

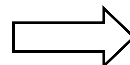
______________Lupus

______________Thyroid Disease

______________Other



***** Please turn this form over and complete other side *****



Social History *this information 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?)

Review of Systems

Are you currently experiencing any problems in the following areas? (*please* ***circle*** *all that applies below*):

Constitutional
Fever, Weight Loss/Gain

Integumentary (skin)

Neurology
- Headaches
- Migraines
- Seizures

Eyes
- Loss of Vision
- Blurred Vision
- Loss of Side Vision
- Double Vision
- Dryness
- Mucous Discharge
- Redness
- Sandy or Gritty Feeling
- Itching
- Burning
- Eye Pain or Soreness
- Excess Tearing/Watering
- Glare/Light Sensitivity
- Tired Eyes
- Chronic Infection of Eye or Lid
- Sties or Chalazion
- Flashes in Vision
- Floaters in Vision

Endocrine
- Thyroid/Other Glands

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

Respiratory
- Asthma
- Chronic Bronchitis

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/Immunological/Psychiatric

DILATION allows the doctor to examine the health of your eyes and to detect certain conditions such as cataracts, glaucoma, diabetes and other eye conditions. You will experience *light sensitivity* and *near vision blur* for a few hours.

Circle YES to accept or NO to decline this service and please initial _____.

HIPAA Notice of Privacy and Financial Policy: We will disclose your health information with your consent or allowed by law. A copy is available upon request. Also, in the event that your medical insurance plan determines that you are not eligible or applies the charges to your deductible, by signing this statement you agree to be financially responsible for any and all of the charges that are not paid by your plan. Any record or prescription is not released until balance is paid in full. Account that is 90 days old is subject to collection.

Signature: ______________________________________ **Date** ______________________

Guardian if patient is a minor