Medical History Questionnaire

Name:_____ Today's Date: _____/_____/_____

Address:_____ Home Phone:_____

_____ Cell Phone:_____

Birth Date: _____/_____/_____ SSN: _____-_____-_____ Last Eye Exam:_____

Email:_____

Medical History

Do you have any allergies to medications? [ ] No [ ] Yes

If yes, please explain:_____

List any medications you currently take (including oral contraceptives, aspirin, OTC medicine or home remedies):

_____

_____

_____

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 current lenses? _____

Do you wear contacts? [ ] No [ ] Yes If yes, how old is your current lenses? _____

Type of contact lenses? [ ] Rigid [ ] Soft [ ] Extended Wear [ ] Other

Are they comfortable? [ ] No [ ] Yes

Family History

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

DISEASE / CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness			
Cataract			
Crossed Eyes			
Glaucoma			
Macular Degeneration			
Retinal Detachment/Disease			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Thyroid Disease			

Please make sure both sides of this form are complete

Social History

This information is kepy 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: _____

Review of Systems

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

Constitutional	NO	YES	?
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/Gritty Feeling	[ ]	[ ]	[ ]
Itching	[ ]	[ ]	[ ]
Burning	[ ]	[ ]	[ ]
Foreign Body Senssation	[ ]	[ ]	[ ]
Excess Tearing/Watering	[ ]	[ ]	[ ]
Glare/Light Sensitivity	[ ]	[ ]	[ ]
Eye Pain/Soreness	[ ]	[ ]	[ ]
Chronic Infection of Eye/Lid	[ ]	[ ]	[ ]
Sties or Chalazion	[ ]	[ ]	[ ]
Flashes/Floaters in Vision	[ ]	[ ]	[ ]
Tired Eyes	[ ]	[ ]	[ ]
Endocrine			
Thyroid/Other Glands	[ ]	[ ]	[ ]
Psychiatric	[ ]	[ ]	[ ]

	NO	YES	?
Ear, Nose, Mouth, Throat			
Allergies/Hay Fever	[ ]	[ ]	[ ]
Sinus Congestion	[ ]	[ ]	[ ]
Runny Nose	[ ]	[ ]	[ ]
Post-Nasal Drop	[ ]	[ ]	[ ]
Chronic Cough	[ ]	[ ]	[ ]
Dry Throat/Mouth	[ ]	[ ]	[ ]
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	[ ]	[ ]	[ ]

By signing below you authorize that our Notice of Privacy Practices, in compliance with the federal regulations of HIPPA's privacy rule, describes how medical information about you may be used and disclosed and how you can obtain access to it. In addition, I understand that I am responsible for payment of services rendered and/or materials ordered/dispensed. I am also responsible for paying any co-payments or deductibles my insurance does not cover. I hereby authorize payment of my insurance benefits directly to this office.

_____ _____

Patient Signature Date