

ease use black ink, thank you!

Medical History Questionnaire

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

Address: _____ Phone: _____

Work Phone: _____

Birth Date: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Last Eye Exam: ____ / ____ / ____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Last Medical Exam: ____ / ____ / ____

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):

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 lenses? _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? yes no

Family History

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

| DISEASE/CONDITION | NO | YES | ? | RELATIONSHIP TO YOU |
|----------------------------|--------------------------|--------------------------|--------------------------|---------------------|
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cataract | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Crossed Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Retinal Detachment/Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Lupus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

* Please turn this form over and complete side two *

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

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

| SYSTEM | NO | YES | ? | | NO | YES | ? |
|---------------------------------|--------------------------|--------------------------|--------------------------|--|----------------------------------|--------------------------|--------------------------|
| CONSTITUTIONAL | | | | | EARS, NOSE, MOUTH, THROAT | | |
| Fever, Weight Loss/Gain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Allergies/Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| INTEGUMENTARY (Skin) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Sinus Congestion | <input type="checkbox"/> | <input type="checkbox"/> |
| NEUROLOGICAL | | | | | Runny Nose | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Post-Nasal Drip | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Dry Throat/Mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| EYES | | | | | RESPIRATORY | | |
| Loss of Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Chronic Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Distorted Vision/Halos | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of Side Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | VASCULAR / CARDIOVASCULAR | | |
| Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Dryness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Heart Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Mucous Discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Redness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Vascular Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Sandy or Gritty Feeling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | GASTROINTESTINAL | | |
| Itching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Constipation | <input type="checkbox"/> | <input type="checkbox"/> |
| Foreign Body Sensation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | GENITOURINARY | | |
| Excess Tearing/Watering | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Genitals/Kidney/Bladder | <input type="checkbox"/> | <input type="checkbox"/> |
| Glare/Light Sensitivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | BONES / JOINTS / MUSCLES | | |
| Eye Pain or Soreness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic Infection of Eye or Lid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Muscle Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Sties or Chalazion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Flashes/Floaters in Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | LYMPHATIC / HEMATOLOGIC | | |
| Tired Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| ENDOCRINE | | | | | Bleeding Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid/Other Glands | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | ALLERGIC / IMMUNOLOGIC | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | PSYCHIATRIC | <input type="checkbox"/> | <input type="checkbox"/> |

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

Doctor's Signature

Date

Patient Information confidential (Please use black ink)

| | | | |
|--|--|------------------|------------------|
| (Please Print) | | | Date _____ |
| Name _____ | | DOB _____ | Home phone _____ |
| Address _____ | City _____ | State _____ | Zip _____ |
| Check appropriate box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated | | | |
| Patient's drivers license # _____ | Patient's social security number _____ | | |
| Employer _____ | Occupation _____ | Work phone _____ | |
| Spouse's name _____ | Employer _____ | Work phone _____ | |
| Person to contact in case of an emergency _____ | | Phone _____ | |
| Whom may we thank for referring you? _____ | | Email _____ | |

Primary Vision Insurance Information

| | |
|---------------------------|----------------------------------|
| Name of insured _____ | Relationship to patient _____ |
| DOB _____ SSN _____ | Date Employed _____ |
| Name of employer _____ | Work phone _____ |
| Address of employer _____ | City _____ State _____ Zip _____ |
| Insurance Company _____ | Phone _____ |

Secondary Vision Insurance Information

| | |
|---------------------------|----------------------------------|
| Name of insured _____ | Relationship to patient _____ |
| DOB _____ SSN _____ | Date Employed _____ |
| Name of employer _____ | Work phone _____ |
| Address of employer _____ | City _____ State _____ Zip _____ |
| Insurance Company _____ | Phone _____ |

Medical Insurance Information

| | |
|---------------------------|----------------------------------|
| Name of insured _____ | Relationship to patient _____ |
| DOB _____ SSN _____ | Date Employed _____ |
| Name of employer _____ | Work phone _____ |
| Address of employer _____ | City _____ State _____ Zip _____ |
| Insurance Company _____ | Phone _____ |

Responsible Party

| | |
|--|-------------------------------|
| Name of person responsible for this account _____ | Relationship to patient _____ |
| Address _____ | Home phone _____ |
| Driver's license # _____ | Birthdate _____ |
| Employer _____ | Social security number _____ |
| Is this person currently a patient in our office? <input type="checkbox"/> Yes <input type="checkbox"/> No | Work phone _____ Ext _____ |

Acknowledgement of Receipt of Privacy Rules

| |
|--|
| Signature _____ |
| <small>Signature of patient or parent if minor</small> |
| <p>Fees for services and materials are due at the time provided. Patient or responsible party is financially responsible for services rendered. While we are pleased to assist in the preparation or submission of insurance forms, the obligation for payment of fees remains that of the patient. If your account is referred to an agency or attorney for collection, you are responsible for all fees charged.</p> |
| Signature _____ |
| <small>Signature of patient or parent if minor</small> |