WELCOME TO OUR OFFICE / MEDICAL HISTORY QUESTIONNAIRE

Name_____Date of Birth____-____-____Today's Date_____

Address_____City_____Zip Code_____

Home Phone_____Cell Phone_____Work Phone_____

Social Security Number:_____ Single____Married____Divorced_____Widow____

Employer/School_____If Student, what grade_____

INSURANCE

Who is Responsible for this account?_____

Relationship to Patient_____Insurance Co._____

Subscribers Date of Birth____/____/____

EYE HEALTH HISTORY

Physician's Name_____Date of Last Medical Exam_____

Date of Last Eye Exam_____

Do You Wear Glasses_____All the time_____Occasionally_____Driving_____TV_____

Do You Wear Contacts_____Type_____How old are your present lenses?_____

Do You Drive? Yes No If yes, do you have any visual difficulty while driving? Explain_____

_____

CHECK ALL THAT APPLY

	NO	YES		NO	YES		NO	YES
Loss of Vision	____	____	Blurred Vision	____	____	Distorted Vision/Halos	____	____
Double Vision	____	____	Dryness	____	____	Loss of Side Vision	____	____
Redness	____	____	Itching	____	____	Sand/Gritty Feeling	____	____
Burning	____	____	Mucous Discharge	____	____	Foreign Body Sensation	____	____
Sties	____	____	Excess Tearing	____	____	Light Sensitivity	____	____
Tired Eyes	____	____	Chronic Infection of the eye/lid	____	____	Floaters in Vision	____	____

Do You Have Any of the Following? (circle all that apply) Crossed Eyes, Lazy Eye, Drooping Eye Lid, Glaucoma, Retinal Disease, Cataracts Eye Infections, Injury/Disease of the Eye.

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 with the doctor.

Do you use Tobacco? YES NO Do you use alcohol? YES NO Do you use illicit drugs? YES NO IF YOU ANSWERED YES TO ANY PLEASE EXPLAIN_____

Have you been exposed to or infected with_____Hepatitis(which one)_____ Gonorrhea_____Syphillis_____HIV_____

Are you pregnant? YES NO If yes, are you nursing? YES NO

FAMILY HISTORY

Please circle any of the following conditions that any member of your family has had (living or deceased) and their relationship to you.

Diabetes Heart Disease Kidney Disease High Blood Pressure Lupus Cancer Thyroid Disease Seizures Arthritis Blindness Glaucoma Crossed Eyes Cataracts Macular Degeneration Retinal Detachment/Disease

Explain_____

_____

_____

List any medications you take (Include over the counter medicines/vitamins)

_____

_____

_____

_____

Do you have any allergies to medicine? If yes, explain_____

_____

List all major injuries, health problems, surgeries or hospitalizations you have had_____

_____

_____

REVIEW OF SYSTEMS

Do you currently or have you ever had any problems in the following areas? If yes, please explain & list medications.

	YES	NO
CONSTITUTION		
Fever, Weight Loss/Gain	____	____
INTEGUMENTARY (Skin)	____	____
NEUROLOGICAL		
Headaches	____	____
Migraines	____	____
GASTROINTESTINAL		
Diarrhea	____	____
Other	____	____
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	____	____
Muscle Pain	____	____
Joint Pain	____	____
ALLERGIC / IMMUNOLOGIC	____	____
PSYCHIATRIC	____	____

	YES	NO
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	____	____
Sinus Congestion	____	____
Other	____	____
RESPIRATORY		
Asthma	____	____
Chronic Bronchitis	____	____
VASCULAR/CARDIOVASCULAR		
Diabetes	____	____
Heart Pain	____	____
High Blood Pressure	____	____
LYMPHATIC / HEMATOLOGIC		
Anemia	____	____
Bleeding Problems	____	____
ENDOCRINE		
Thyroid / Other Glands	____	____

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

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature **Date**

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the doctor and I am responsible for any uncovered fees for materials and services. I also authorize the doctor to release any information required to process the claim.

Signature_____**Date**_____