Medical History Questionnaire

Name: _____ Today's Date: ____/____/_____
Address: _____ Phone: _____
_____ Work Phone: _____
Guardian (If Applicable): _____ Occupation: _____
Birth Date: ____/____/_____ Social Security #: ____/____/____ Last Eye Exam: ____/____/_____
Drivers License Number: _____ Dr.'s Phone: _____
Name of Medical Doctor: _____ Last Medical Exam: ____/____/_____

Who can we thank for referring you to 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):
_____
_____
_____
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 - Family Members

Name	Age	Relationship	Name	Age	Relationship
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

Insurance
Who is responsible for this account? _____
Relationship to Patient _____ Insurance Co. _____
Group # _____ Is patient covered by additional insurance? ☐ yes ☐ no
Relationship to Patient _____ Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE
I certify that I, and / or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent or Guardian Please print name of Patient, Parent or Guardian

_____ _____
Date Relationship to Patient

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	FAMILY
CONSITUTIONAL			
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 or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing / Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes / Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Blindness	☐	☐	☐
Cataract	☐	☐	☐
Crossed Eyes	☐	☐	☐
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
Retinal Detachment / Disease	☐	☐	☐
ENDOCRINE			
Thyroid / Other Glands	☐	☐	☐
EARS, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat / Mouth	☐	☐	☐
RESPRITORY			
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	☐	☐	☐
PSHYCHIATRIC	☐	☐	☐
OTHER			
Cancer	☐	☐	☐
Lupus	☐	☐	☐
Other _____	☐	☐	☐

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

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date