

Medical History Questionnaire

Dear Patient:

All major health insurers and Medicare now **require** us to obtain in depth patient medical history information. We apologize for the time required to fill out this form and thank you for your cooperation.

Name:	_____	Today's Date:	_____ / _____ / _____
Address:	_____	Home Phone:	_____
City, State, Zip:	_____	Work Phone:	_____
Social Sec. #	_____ / _____ / _____	Sex:	_____ M _____ F
Date of Birth:	_____ / _____ / _____	Age:	_____
Primary Care Physician:	_____	Occupation:	_____
Last Medical Exam:	_____ / _____ / _____	Employer:	_____
Last Eye Doctor:	_____	Insured's Name:	_____
Last Eye Exam:	_____ / _____ / _____	Insured's Soc. Sec.#	_____ / _____ / _____
May we contact you via Email?	<input type="checkbox"/> no <input type="checkbox"/> yes	Email Address:	_____
How did you hear about us?	_____		

Medical History:

Reason for Visit: routine annual exam need new glasses lost or broken glasses
 contact lenses interested in lasik laser vision correction

Do you have any specific questions or problems you would like to discuss with your doctor?

If yes, please explain: _____

Are you allergic to any medications? no yes

If yes, please explain: _____

Are you pregnant and/or nursing? no yes

Please list any medications you are currently taking: _____

Personal Eye History:

Have you ever worn glasses? no yes If yes, how old are your current glasses? _____

Do you currently wear contact lenses? no yes

Type of contact lenses: disposables gas perm soft bifocal other

Have you ever had lasik or refractive surgery? no yes If yes, date: _____ / _____ / _____

Have you ever had eye surgery? If yes, please describe: _____

Check any of the following that you have had: crossed eyes lazy eye drooping eyelid
 prominent eyes glaucoma retinal disease
 cataracts eye injury serious eye infection

How many hours a day do you work on a computer? _____

<Please Turn This Form Over And Complete Side Two>

Review of Systems:

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

	<u>NO</u>	<u>YES</u>		<u>NO</u>	<u>YES</u>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE (Thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL (Headaches)	<input type="checkbox"/>	<input type="checkbox"/>	EARS, NOSE, MOUTH, THROAT (Allergies)	<input type="checkbox"/>	<input type="checkbox"/>
CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY	<input type="checkbox"/>	<input type="checkbox"/>
EYES	<input type="checkbox"/>	<input type="checkbox"/>	CARDIOVASCULAR	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	<input type="checkbox"/>	<input type="checkbox"/>	MUSCULOSKELETAL	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIC/IMMUNE	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL	<input type="checkbox"/>	<input type="checkbox"/>
GENITOURINARY	<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____		

If you answered YES to any of the above or are currently under the care of a physician for any condition not listed above, please explain:

Social History: *This information is kept strictly confidential. Please answer all questions that apply.*

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 Do you drink alcohol? no yes
 Do you use illegal drugs? no yes

Family History:

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

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

I acknowledge that I have been made aware of the HIPPA Notice Of Privacy Practices.

Patient Name _____ **Signature** _____ **Date** _____

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Doctor's Signature

Date