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? ☐ no ☐ 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 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 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 your computer? _____

Review of Systems:

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

Diabetes	☐ No ☐ Yes	Blood	☐ No ☐ Yes
High Blood Pressure	☐ No ☐ Yes	Endocrine (Thyroid)	☐ No ☐ Yes
Neurological (Headaches)	☐ No ☐ Yes	Ears, Nose, Mouth, Throat	☐ No ☐ Yes
Cholesterol	☐ No ☐ Yes	Respiratory	☐ No ☐ Yes
Eyes	☐ No ☐ Yes	Cardiovascular	☐ No ☐ Yes
Cancer	☐ No ☐ Yes	Gastrointestinal	☐ No ☐ Yes
Skin	☐ No ☐ Yes	Musculoskeletal	☐ No ☐ Yes
Allergic / Immune	☐ No ☐ Yes	Mental	☐ No ☐ Yes
Genitourinary	☐ No ☐ Yes	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 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	☐	☐	_____
Macular Degeneration	☐	☐	_____
Cataract	☐	☐	_____
Retinal Detachment / Disease	☐	☐	_____
Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____
Crossed Eyes	☐	☐	_____
Blindness	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Heart Disease	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Thyroid Disease	☐	☐	_____

Other: _____

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

Patient Name _____Signature _____Date _____

_____ _____

Doctor's Signature **Date**