Medical History Questionnaire

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

Address: ______________________ Town/City: Zip Code: Phone: ______________

Employer: ______________________ Work: ______________ Cell:

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

Name of Medical Doctor: ______________________ Dr.'s Phone: ______________

Emergengy Contact: ______________________ 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, catar. 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	❑	❑	❑	
Cataract	❑	❑	❑	
Crossed Eyes	❑	❑	❑	
Glaucoma	❑	❑	❑	
Macular Degeneration	❑	❑	❑	
Retinal Detachment/Disease	❑	❑	❑	
Arthritis	❑	❑	❑	
Cancer	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
High Blood Pressure	❑	❑	❑	
Kidney Disease	❑	❑	❑	
Lupus	❑	❑	❑	
Thyroid Disease	❑	❑	❑	
Other ______________	❑	❑	❑	

✱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	?
CONSTITUTIONAL			
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	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐

SYSTEM	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
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	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

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

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____

____________________ Doctor's Signature ____________________ Date

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CHILDREN'S DATA FORM

NAME OF PATIENT:____
ADDRESS:____

DATE OF BIRTH:______________________ HOME PHONE #:___________________________
SCHOOL:______________________________ GRADE:_________

NAME OF MOTHER:_____________________ SOCIAL SECURITY #________________________
ADDRESS:____________________________ HOME PHONE #____________________________
CELL PHONE #______________________________
EMPLOYER:__________________________ WORK PHONE #____________________________

NAME OF FATHER:______________________ EMPLOYER:_______________________________
WORK PHONE #:______________________ SOCIAL SECURITY#:_______________________
ADDRESS:____________________________ HOME PHONE #__________________________
CELL PHONE #:_______________________

List siblings and ages:____

How is the child doing in school? ____

Has the child had any special testing in school?____
If so, when and what type?____
Does child live with both parents?__________________________
If not, with whom does the child live?________________________
Who referred you to our office and why?____
Describe any visual symptoms or problems:____

When was your child's last eye examination?________Where was this done?___________
How much time does child spend using a computer?___________________________
Do your child's eyes get tired from doing close work?____
What hobbies/sports does he/she enjoy?______________________________________
Who is his/her physician?_____________When was his/her last visit?______________ List any medications he/she is taking and why:____

Please list any unusal medical history.____
To what medications is he/she allergic?____
Any other allergies?____
Is there a family history of diabetes?______Hypertension?_______Glaucoma?____
Insurance Carrier:________________________Policy ID #:____________________

Office Policy: It is expected that fees are paid at the time of service. We accept cash, checks, Visa, and Mastercard. Deposits are required for any lab work at the time of the order. Accounts not paid in a timely manner will be subject to a monthly (1.5%) finance charge. If accounts need to be sent to collection, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 29% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts. Insurance forms will be filed when possible, but the parent or guardian is responsible for payment of all fees. Patients with managed-care plans are totally responsible for their copayments and services NOT covered by their plans.

Signature of Parent or legal guardian:____________________________________ Date:__________________