Medical History Questionnaire

Name: _____Today's Date :_____/_____/_____

Address: Street_____Phone:_____

City_____State_____Zip_____Cell:_____

Employer: _____Business Phone: _____

Occupation: _____E-Mail: _____

Age: _____ Birth Date: _____ /_____/_____ Social Security#:_____Full Time Student ☐YES ☐NO

Insurance information must be presented at time of service. Our office will NOT bill after services rendered.

Initial_____

Vision Insurance: _____Health Insurance: _____

Primary Member's Name: _____Birth Date_____/____/_____ SS/ID #_____

Relationship to Primary Member: _____Spouses or Parents Names: _____

Medical History

Name of Medical Doctor (PCP):_____Phone:_____ Last Exam: _____/_____/_____

Name of Last Eye Doctor: _____**Phone**:_____ Last Exam: _____/_____/_____

Do you have any allergies to medication? ☐ NO ☐ YES **If yes**, explain: _____

List any medications you take (include nonprescription):_____

_____

_____

_____

List all major injuries, surgeries or hospitalizations you have had: _____

_____

Are you pregnant or nursing? ☐ YES ☐ NO

Family History

Please check mark any condition present in your family (blood relatives) and list their relationship to you:

History Unknown ☐

Blindness ☐ _____ Cataract ☐ _____ Crossed Eyes ☐ _____

Glaucoma ☐ _____ Macular Degeneration ☐ _____ Retinal Detachment/Degeneration ☐ _____

Arthritis ☐ _____ Cancer ☐ _____ Diabetes ☐ _____

Heart Disease ☐ _____ High Blood Pressure ☐ _____ Kidney Disease ☐ _____

Lupus ☐ _____ Thyroid Disease ☐ _____Other ☐ _____

**** Please turn this form over and complete back side ****

Social History (*You may discuss this portion directly with the doctor if you prefer.)*

☐ Yes, I would prefer to discuss my Social History information directly with the doctor. (Check box)

Do you drive? □ NO □ YES If yes, do you have visual difficulty when driving? ☐ NO ☐ YES If yes, describe: _____
_____.

Check any that apply: Do you use ☐ tobacco, ☐ alcohol, ☐ illegal drugs If yes, type /amount/ how long _____
_____.

Check any that apply: Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of systems

Do you have persistent problems in the following areas: (check all that apply?)

CONSTITUTIONAL: ☐ Fever ☐ Weight Gain ☐ Weight Loss

NEUROLOGICAL: ☐ Headaches ☐ Migraines ☐ Seizures ☐ MS ☐ Other

EARS, NOSE, MOUTH, THROAT: ☐ Hay Fever ☐ Sinus ☐ Cough ☐ Dry Mouth

VASCULAR: ☐ Heart Disease ☐ High Blood Pressure ☐ Vascular Disease

GENITOURINARY: ☐ Genitals ☐ Kidney ☐ Bladder

HEMATOLOGIC: ☐ Anemia ☐ Bleeding Problems

EYES: ☐ Loss of Vision ☐ Blurred Vision ☐ Distorted Vision ☐ Halos
☐ Dryness ☐ Redness ☐ Itching ☐ Burning ☐ Mucous Discharge ☐ Tired Eyes
☐ Sandy/ Gritty Feeling ☐ Foreign Body Sensation ☐ Excess Tearing/ Watering
☐ Glare ☐ Light Sensitivity ☐ Eye Pain or Soreness ☐ Sties or Chalazion ☐ Flashes ☐ Floaters
☐ Chronic Infection of Eye or Lid ☐ Crossed Eyes ☐ Lazy Eye ☐ Drooping Eyelid ☐ Double Vision
☐ Glaucoma ☐ Retinal Disease ☐ Cataracts ☐ Contact Lens Discomfort

INTEGUMENTARY ☐ Skin Diseases

ENDOCRINE: ☐ Thyroid ☐ Diabetes ☐ Other

PSYCHIATRIC: ☐

GASTOINTESTNAL: ☐ Diarrhea ☐ Constipation

BONES/JOINTS/MUSCLES: ☐ Arthritis ☐ Pain

ALLERGIC/IMMUNOLOGIC: ☐

RESPIRATORY: ☐ Asthma ☐ Bronchitis ☐ Emphysema

Do you wear glasses for □ distance vision ☐ for near vision ☐ or both? **How old is your current pair of lenses?** _____

Do you wear contact lenses? ☐ YES ☐ NO **If no,** are you interested in wearing contact lenses? ☐ YES ☐NO

If you checked any of the above or have a condition not listed, please explain, and list medications if not already listed: _____

_____

Optomap Retinal Examination

Optomap Retinal Examination is a new procedure that can take an ultra-wide picture of the retina, allowing the doctor to do a more accurate internal assessment of the eye. The Optomap can be done with or without dilation. If you wish not to have your eyes dilated, the Optomap image gives the doctor a much larger image of the retina. The fee for the Optomap is $30.00.

Do you want the Optomap ☐ YES ☐ NO

Pupil Dilation

Dilation drops enlarge the size of the pupil. This allows a thorough examination of the health of your retina. The effect of the dilation normally last three to five hours. In most cases, distance vision is not impaired. Dilation is part of the comprehensive exam with no additional c harge.

Do you want the pupil dilation? **☐ YES ☐ NO**

Visual Field Screening

Computerized Visual Testing can assist us in early detection of glaucoma, retinal problems, and some neurological diseases.
The fee for this test is $25.00. For more in-depth field-testing there is an additional charge.

Do you want the Visual Field Screening? **☐ YES ☐ NO**

Office Policies

All copays and service fees are expected at time service is rendered. Fees for eye exams and contact evaluation/fittings are all separate charges and non refundable.

Signature_____