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 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:

	NO	YES		NO	YES
DIABETES	❑	❑	BLOOD	❑	❑
HIGH BLOOD PRESSURE	❑	❑	ENDOCRINE (Thyroid)	❑	❑
NEUROLOGICAL (Headaches)	❑	❑	EARS, NOSE, MOUTH, THROAT (Allergies)	❑	❑
CHOLESTEROL	❑	❑	RESPIRATORY	❑	❑
EYES	❑	❑	CARDIOVASCULAR	❑	❑
CANCER	❑	❑	GASTROINTESTINAL	❑	❑
SKIN	❑	❑	MUSCULOSKELETAL	❑	❑
ALLERGIC/IMMUNE	❑	❑	MENTAL	❑	❑
GENITOURINARY	❑	❑	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	❑	❑	
Macular Degeneration	❑	❑	
Cataract	❑	❑	
Retinal Detachment/Disease	❑	❑	
Diabetes	❑	❑	
High Blood Pressure	❑	❑	
Crossed Eyes	❑	❑	
Blindness	❑	❑	
Arthritis	❑	❑	
Cancer	❑	❑	
Heart Disease	❑	❑	
Kidney Disease	❑	❑	
Lupus	❑	❑	
Thyroid Disease	❑	❑	

Other: _____

Thank You!

Doctor's Signature Date

09/02