MEDICAL HISTORY QUESTIONNAIRE

Name ______________________ S.S. # __________ SEX ❑ M ❑ F Today's Date: ________

Address:______________________________________ Phone: ______________

______________________________________ W/Phone: ______________

Employer:______________ Occupation:____________ Cell Phone:______________

Referred by:______________________ Email Address: ______________________

Date of Birth:_____ / ____ / ____ Age:_____ Number of hours of computer use per day = _____ Hobbies / Sports:_______

Marital Status: ❑ Married ❑ Single ❑ Other __________ ❑ Living with Family ❑ Friend ❑ Alone ❑ Other __________

Reason for today's visit: ______________________________________

Last Eye Exam Date: __________ with Dr. ______________ , Last Physical Date: _________ , with Dr. ____________

MEDICAL HISTORY

Marital Status: ❑ Married ❑ Single ❑ Other __________ ❑ Living with Family ❑ Friend ❑ Alone ❑ Other __________

____

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, cataracts, 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, Type of contact lenses: ❑ Rigig ❑ Soft ❑ Extended Wear

When did you first begin wearing contact lenses?______________ Are they comfortable now? __________

Are you interested in trying contact lenss? ❑ NO ❑ YES

SOCIAL HISTORY *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Do you drive? ❑ NO ❑ YES If yes, do you have visual difficulty when driving ❑ YES ❑ NO 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: ______________________

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphiis ❑ No Exposure/Infection

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	DISEASE CONDITION	NO	YES	RELATIONSHIP TO YOU
• BLINDNESS	❑	❑	__________	• CANCER	❑	❑	__________
• CATARACT	❑	❑	__________	• DIABETES	❑	❑	__________
• CROSSED EYES	❑	❑	__________	• KIDNEY DISEASE	❑	❑	__________
• GLAUCOMA	❑	❑	__________	• HEART DISEASE	❑	❑	__________
• MACULAR DEGENERATION	❑	❑	__________	• LUPUS	❑	❑	__________
• RETINAL DETACHMENT/DISEASE	❑	❑	__________	• THYROID DISEASE	❑	❑	__________
• ARTHRITIS	❑	❑		• HIGH BLOOD PRESSURE	❑	❑	__________
				• OTHER	❑	❑	__________

PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO

REVIEW OF SYSTEMS Do you currently have or are any of the following conditions pertinent to today's exam?

SYSTEM	NO	YES	
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❑	❑	____________
CONSTITUTIONAL (skin)	❑	❑	____________
NEUROLOGICAL			
Headaches	❑	❑	____________
Migraines	❑	❑	____________
Seizures	❑	❑	____________
EYES			
Loss of Vision	❑	❑	____________
Blurred Vision	❑	❑	____________
Distorted Vision / Halos	❑	❑	____________
Double Vision	❑	❑	____________
Loss of Side Vision	❑	❑	____________
Dryness	❑	❑	____________
Mucous Discharge	❑	❑	____________
Redness	❑	❑	____________
Sandy / Gritty Feeling	❑	❑	____________
Itching	❑	❑	____________
Burning	❑	❑	____________
Foreign Body Sensation	❑	❑	____________
Excess Tearing / Watering	❑	❑	____________
Glare/Light Sensitivity	❑	❑	____________
Eye Pain or Soreness	❑	❑	____________
Chronic Infection Eye/Lid	❑	❑	____________
Sties or Chalazion	❑	❑	____________
Flashes/Floaters in Vision	❑	❑	____________
Tired Eyes	❑	❑	____________
ENDOCRINE	❑	❑	____________
Tired Eyes	❑	❑	____________

EARS, NOSE, MOUTH THROAT	NO	YES	
Hearing Loss / Disability	❑	❑	____________
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	❑	❑	____________

Is there any other ocular or systemic conditions or anything else that you would like the doctor to know concerning your eye examination today?: ____

____

________________________________ ____________________

Doctor's Signature Date

PRIMARY INSURANCE HOLDER: Name: ______________________ Date of Birth: ____________

Address: ______________________ Soc. Sec. #: ____________

NAME OF INSURANCE COMPANY: ______________________ **ID#:** ____________

PERSONS RESPONSIBLE FOR PAYMENT: Name: ______________________

Address: ____

I hereby grant my insurance carrier to pay Eye Associates directly.

I understand that if my insurance carrier doesn't cover all or part of my expenses, I am responsible to payment in full.

Signature of patient or guardian ____