

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: Rigid Soft Extended Wear

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

Are you interested in trying contact lens? 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 Syphilis 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	<input type="checkbox"/>	<input type="checkbox"/>	_____	• CANCER	<input type="checkbox"/>	<input type="checkbox"/>	_____
• CATARACT	<input type="checkbox"/>	<input type="checkbox"/>	_____	• DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
• CROSSED EYES	<input type="checkbox"/>	<input type="checkbox"/>	_____	• KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
• GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	_____	• HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
• MACULAR DEGENERATION	<input type="checkbox"/>	<input type="checkbox"/>	_____	• LUPUS	<input type="checkbox"/>	<input type="checkbox"/>	_____
• RETINAL DETACHMENT/DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____	• THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
• ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	_____	• HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	_____
				• OTHER	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

SYSTEM	NO	YES	EARS, NOSE, MOUTH THROAT	NO	YES
CONSTITUTIONAL			Hearing Loss / Disability	<input type="checkbox"/>	<input type="checkbox"/>
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
CONSTITUTIONAL (skin)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL			Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>
EYES			RESPIRATORY		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision / Halos	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARDIOVASCULAR		
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sandy / Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY		
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	BONES/JOINTS/MUSCLES		
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC		
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>
			PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>

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 _____

PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO