MEDICAL HISTORY QUESTIONNAIRE

PATIENT INFORMATION

FULL NAME: _____ TODAY'S DATE__ ____/_____/_____

MAILING ADDRESS: _____ PHONE: _____

CITY, STATE ZIPCODE:_____ CELL: _____

BIRTH DATE: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____ SEX: _____MALE _____FEMALE

E-MAIL_____ LAST MEDICAL EXAM: _____ LAST EYE EXAM: _____/_____

PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS *(Please Circle):* Cell Home Phone Email Text Message

MEDICAL DOCTOR:_____ PREVIOUS EYE DR._____

MARITAL STATUS: _____ SPOUSE'S NAME_____

OCCUPATION:_____ ___FULL TIME___PART TIME___RETIRED ___STUDENT SCHOOL:_____

EMPLOYER:_____ WORK PHONE:_____

VISION INSURANCE_____ PRIMARY MEDICAL INSURANCE_____

HOW DID YOU HEAR ABOUT OUR OFFICE? (Please Circle) Insurance website Google Yelp Walk By

Krystal 93 The Lift Summit Daily Other _____

*IS THERE SOMEONE WE CAN THANK FOR REFERRING YOU?*_____ _____

INSURED PARTY INFORMATION (if self continue to next section)

INSURED NAME: _____ RELATIONSHIP TO PT._____

INSURED ADDRESS: _____ PHONE:_____ BIRTH DATE:___/___/___(insured)

EMPLOYER:_____ WORK PHONE:_____

EMPLOYER ADDRESS:_____

MEDICAL HISTORY

List any medications you take (including oral contraceptives, aspirin, over the counter medications and vitamins):_____

_____

Do you have any environmental allergies or allergies to medications? ___YES___NO If yes, please explain: _____

_____

List all major injuries, surgeries and/or hospitalizations:_____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infection or eye injury:_____

Do you wear glasses? ____YES ____NO If yes, how old is your present pair?_____

Do you wear contacts? ____YES ____NO If yes, what type do you wear?_____

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	□	□	_____
Cataracts	□	□	_____
Crossed Eyes	□	□	_____
Glaucoma	□	□	_____
Macular Degeneration	□	□	_____
Retinal Detachment/Disease	□	□	_____
Cancer	□	□	_____
Diabetes	□	□	_____
Heart Disease	□	□	_____
High Blood Pressure	□	□	_____
Autoimmune Disease	□	□	_____
Thyroid Disease	□	□	_____
Other _____	□	□	_____

SOCIAL HISTORY

Do you drive? □ no □ yes If yes, do you have a visual difficulty when driving? □ no □ yes If yes, please describe:

_____

Do you use tobacco products? □ no □ yes If yes, what type? Amount? How many years? _____

Do you smoke marijuana? □ no □ yes If yes, Amount? How many years? _____

Do you drink alcohol? □ no □ yes If yes, what type? Amount? How many years? _____

Do you use illegal drugs? □ no □ yes If yes, what type? Amount? How many years? _____

What hobbies do you have? _____

Any vision concerns/difficulties while completing these hobbies? _____

How many hours a day do you spend on digital devices (phone, computer, tablet)? _____

Do your eyes turn red at the end of the day, after reading, or after using a computer? _____

When reading, do you often skip lines, forget what you read, or find the words move on the page? _____

Do you get headaches after reading or at the end of the day? _____

REVIEW OF SYSTEMS

Do you currently or have any problems in the following areas:

SYSTEM	NO	YES	?	SYSTEM	NO	YES	?
CONSTITUTIONAL				**EARS, NOSE, MOUTH, THROAT**			
Fever, Weight Loss/Gain	□	□	□	Allergies/Hay Fever	□	□	□
INTEGUMENTARY (Skin)	□	□	□	Sinus Congestion	□	□	□
NEUROLOGICAL				Runny Nose	□	□	□
Headaches	□	□	□	Post Nasal Drip	□	□	□
Migraines	□	□	□	Chronic Cough	□	□	□
Seizures	□	□	□	Dry Throat/Mouth	□	□	□

SYSTEM		NO	YES	?	SYSTEM		NO	YES	?
EYES RESPIRATORY									
Loss of Vision	□	□	□		Asthma	□	□	□	
Blurred Vision	□	□	□		Chronic Bronchitis	□	□	□	
Distorted Vision/Halos	□	□	□		Emphysema	□	□	□	
Loss of Side Vision	□	□	□		**VASCULAR / CARDIOVASCULAR**				
Double Vision	□	□	□		Diabetes	□	□	□	
Dryness	□	□	□		Heart Pain	□	□	□	
Mucous Discharge	□	□	□		High Blood Pressure	□	□	□	
Redness	□	□	□		Vascular Disease	□	□	□	
Sandy or Gritty Feeling	□	□	□		**GASTROINTESTIONAL**				
Itching	□	□	□		Diarrhea	□	□	□	
Burning	□	□	□		Constipation	□	□	□	
Foreign Body Sensation	□	□	□		**GENITOURINARY**				
Excess Tearing/Watering	□	□	□		Kidney/Bladder	□	□	□	
Glare/Light Sensitivity	□	□	□		**BONES / JOINTS / MUSCLES**				
Eye Pain/Soreness	□	□	□		Rheumatoid Arthritis	□	□	□	
Chronic Infection of Eye or Lid	□	□	□		Osteoarthritis	□	□	□	
Chronic Stye/Chalazion	□	□	□		Muscle/Joint Pain	□	□	□	
Flashes/Floaters in Vision	□	□	□		**LYMPHATIC / HEMATOLOGIC**				
Tired Eyes	□	□	□		Anemia	□	□	□	
ENDOCRINE					Bleeding Problems	□	□	□	
Thyroid Dysfunction	□	□	□		**ALLERGIC / IMMUNOLOGIC**	□	□	□	
Other Gland Dysfunction	□	□	□		**PSYCHIATRIC**	□	□	□	

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

_____

_____

_____

_____

_____

Do you have any concerns you specifically want addressed today by the doctor?

_____

_____

_____

_____ _____

Patient Signature Date

Thank you for taking the time to complete this health history form. Please click the submit button and return the tablet to the front desk!