Medical History Questionnaire

Today's Date:____/___/___

Basic Information

Name: _____ Birth Date: _____/_____/_____

Address: _____ Phone #: (_____) _____-_____

_____ E-mail: _____

Name and address of pharmacy: _____

Race: □ American Indian or Alaska Native
□ Asian
□ African American
□ Hispanic
□ Native Hawaiian/Pacific Islander
□ Caucasian

Ethnicity:
□ Hispanic or Latino
□ Native Hawaiian/Pacific Islander
□ Caucasian

What is your preferred language?
□ English
□ Spanish

What is your preferred form of communication?
□ Email
□ Postal Mail
□ Telephone

What is your occupation? _____ If you are a student, what is your grade? _____

What is your reason for today's visit?

A. Routine Eye Exam □ For glasses only □ For contacts and glasses

B. Medical Exam □ Red Eye □ Injury/Abrasion □ Other _____

Ocular History

Date of Last Eye Exam: -------/-------/----------

Do you currently wear glasses? Yes No

Do you currently wear contacts? Yes No

Have you had Laser Vision Correction surgery? Yes No

If you do not wear contacts, are you interested? Yes No

Please circle any condition you have had:

Eye Injury Cataracts Lazy Eye Retinal Disease

Eye Surgery Glaucoma Crossed Eyes Chronic Eye Infections

Please check any of the following that you are experiencing:

	Yes	No		Yes	No		Yes	No
Blurred Vision- distance	□	□	Itching	□	□	Eye Pain	□	□
Blurred Vision- near	□	□	Burning	□	□	Red Eye	□	□
Loss of Vision	□	□	Dryness	□	□	Watery Eyes	□	□
Double Vision	□	□	Light Sensitivity	□	□	Discharge	□	□
Poor Night Vision	□	□	Flashes or Floaters	□	□	Sandy/Gritty Feeling	□	□
Headaches	□	□	Halos	□	□			

Social History

□ *I would prefer to discuss my Social History information with my doctor.*

Are you pregnant or nursing? Yes No

Do you drink alcohol? Yes No

Do you use tobacco products? Yes No

Do you use illegal drugs? Yes No

Have you ever been exposed to or infected with: (circle) Gonorrhea Hepatitis HIV Syphilis None

Medical History

Most recent weight? _____ Most recent height? _____ Date of Last Medical Exam: _____/_____/_____

Name of Medical Doctor: _____

Do you have allergies to any medications? Yes No

If yes, please list: _____

List any medications you take (including vitamins, eye drops, birth control): _____

_____

List any major injuries, surgeries and/or hospitalizations you have had: _____

_____

please turn over

Review of Systems

Do you have diabetes? Yes No If yes, since when? _____

If yes, what was your last a1c blood reading? _____ *Date of last blood test*_____

Do you check your blood sugar at home? _____ *What was last blood sugar level?* _____

Name and address of Diabetic Doctor: _____

_____

Do you have high blood pressure? Yes No If yes, since when? _____

Do you have high cholesterol? Yes No If yes, since when? _____

Do you currently, or have you ever had any problems in the following areas? Check all that apply.

	Yes	No		Yes	No		Yes	No
ALLERGIC			GENITOURINARY			NEUROLOGIC		
Environmental	□	□	Genitals	□	□	Headaches	□	□
Medicine	□	□	Kidneys	□	□	Migraines	□	□
Food	□	□	Bladder	□	□	Seizures	□	□
CARDIOVASCULAR			HEAD, EAR, NOSE, THROAT			Brain Tumor	□	□
High Blood Pressure	□	□	Sinus	□	□	Multiple Sclerosis	□	□
Elevated Cholesterol	□	□	Cough	□	□	PSYCHIATRIC		
Vascular Disease	□	□	Dry Mouth	□	□	Depression	□	□
CONSTITUTIONAL			Ear Infections	□	□	Anxiety	□	□
Fever	□	□	HEMATOLOGIC			Bipolar	□	□
Weight Loss	□	□	Anemia	□	□	Dementia	□	□
ENDOCRINE			Bleeding Problems	□	□	RESPIRATORY		
Diabetes	□	□	MUSCULOSKELETAL			Asthma	□	□
Thyroid Problems	□	□	Arthritis	□	□	Bronchitis	□	□
Other Glands	□	□	Rheumatoid Arthritis	□	□			
GASTROINTESTINAL			Osteoporosis	□	□			
Diarrhea	□	□	Joint Pain	□	□			
Constipation	□	□	Lupus	□	□			

Ocular and Medical Family History

Please note any family history (parents, grandparents, siblings, children; etc.) for the following conditions:

OCULAR	Yes	No	Relationship	MEDICAL	Yes	No	Relationship
Glaucoma	□	□	_____	Arthritis	□	□	_____
Macular Degeneration	□	□	_____	Cancer	□	□	_____
Retinal Detachment/Disease	□	□	_____	Diabetes	□	□	_____
Blindness	□	□	_____	Heart Disease	□	□	_____
Cataract	□	□	_____	High Blood Pressure	□	□	_____
Crossed Eyes	□	□	_____	Lupus	□	□	_____

Your Doctor may suggest performing services that may not be covered by your insurance.
Dilation is indicated for new patients, diabetics, highly near-sighted individuals or people having a history of eye health problems.
A Visual Field or Retinal Photograph may be required based on the clinical findings of your exam.
Additional fees if your insurance does not cover these services are as follows:

Dilation	$35
Visual Field	$35
Digital Retinal Photograph	$20
Optical Coherence Tomography	$35
Standard Contact Lens Fit	$50
Refraction (**Medicare only**)	$50

Please be aware payment will be due as services are rendered. If you do not want to have these services performed, please let your doctor know at the beginning of your exam.

By signing below, you confirm that you are aware of the fees listed above and that the medical information provided on this form is complete, true and accurate to the best of your knowledge.

Patient's Signature: _____ Date: _____/_____/_____

Doctor's Signature: _____ Date: _____/_____/_____