

DATE: _____

ACCT # _____

MEDICAL HISTORY QUESTIONNAIRE

YOUR PHYSICIAN WOULD LIKE TO PROVIDE YOU WITH THE HIGHEST QUALITY CARE POSSIBLE. TO ASSIST HIM/HER, WE ASK THAT YOU COMPLETE THE FOLLOWING MEDICAL HISTORY SO THAT YOUR OVERALL HEALTH MAY BE ASSESSED AND INCORPORATED INTO YOUR EYE CARE.

NAME	DOB	GENDER	M	F
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REFERRING PHYSICIAN

PRIMARY CARE PHYSICIAN

EMAIL ADDRESS

PATIENT EYE HISTORY

	RIGHT	LEFT		RIGHT	LEFT
AMBLYOPIA	_____	_____	MUSCLE DISORDER	_____	_____
CATARACT	_____	_____	LACRIMAL OBSTRUCTION	_____	_____
CORNEAL TRANSPLANT	_____	_____	MACULAR DEGENERATION	_____	_____
DIABETIC RETINOPATHY	_____	_____	RETINAL DETACHMENT	_____	_____
GLAUCOMA	_____	_____	IRITIS	_____	_____
EYE INJURY	_____	_____	DATE OF INJURY	_____	_____
DESCRIBE EYE INJURY	_____				
HAVE YOU HAD EYE SURGERY	_____	_____	DATE OF SURGERY	_____	_____
TYPE OF SURGERY	_____		SURGICAL PHYSICIAN	_____	
HAVE YOU EVER WORN GLASSES OR CONTACT LENSES?	_____		HOW OLD ARE THEY?	_____	
HAVE YOU EVER CONSIDERED REFRACTIVE SURGERY (LASIK)?	_____				

PATIENT GENERAL HISTORY

	YES	NO		YES	NO
SKIN DISEASE	_____	_____	DIABETES/SUGAR	_____	_____
HEAD (HEADACHE)	_____	_____	CANCER	_____	_____
EAR/NOSE/THROAT/MOUTH	_____	_____	CHOLESTEROL	_____	_____
LUNGS/BREATHING (TB/ASTHMA)	_____	_____	THYROID	_____	_____
HEART DISEASE	_____	_____	ALLERGIES	_____	_____
HIGH BLOOD PRESSURE	_____	_____	KIDNEY STONES	_____	_____
STOMACH/INTESTINES	_____	_____	URINARY	_____	_____
GENITALS/KIDNEY/BLADDER	_____	_____	BLEEDING DISORDER	_____	_____
ARTHRITIS	_____	_____	BLOOD (HIV/HEPATITIS)	_____	_____
BONES/JOINTS/MUSCLES	_____	_____	INFECTIOUS DISEASE	_____	_____
NEURO/STROKE	_____	_____	PSYCHIATRIC	_____	_____
LYMPH NODES/SWELLING	_____	_____	OTHER	_____	_____

GENERAL SURGERIES

1	_____	DATE	_____	COMPLICATIONS (IF ANY)	_____
2	_____	DATE	_____	COMPLICATIONS (IF ANY)	_____
3	_____	DATE	_____	COMPLICATIONS (IF ANY)	_____
4	_____	DATE	_____	COMPLICATIONS (IF ANY)	_____

PLEASE COMPLETE BACK OF FORM

MEDICATIONS

LIST ALL MEDICATIONS (INCLUDING DOSAGES) AND OVER-THE-COUNTER AND VITAMINS/SUPPLEMENTS

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU ON BLOOD THINNERS? _____ IF YES, WHICH? _____

DRUG ALLERGIES _____

LIST ALL **EYE** MEDICATIONS/DROPS YOU USE, INCLUDING OVER-THE-COUNTER

_____	_____	_____
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FAMILY HISTORY

	YES	NO	FATHER	MOTHER	SIBLING	OTHER
BLINDNESS	_____	_____	_____	_____	_____	_____
CATARACTS	_____	_____	_____	_____	_____	_____
GLAUCOMA	_____	_____	_____	_____	_____	_____
MACULAR DEGENERATION	_____	_____	_____	_____	_____	_____
STRABISMUS	_____	_____	_____	_____	_____	_____
DIABETES	_____	_____	_____	_____	_____	_____
HEART DISEASE	_____	_____	_____	_____	_____	_____
HIGH BLOOD PRESSURE	_____	_____	_____	_____	_____	_____
THYROID DISEASE	_____	_____	_____	_____	_____	_____

SOCIAL HISTORY

MARITAL STATUS	S	M	W	D		
	YES	NO			YES	NO
LIVE ALONE?	_____	_____			NURSING HOME?	_____
DO YOU SMOKE?	_____	_____			CHEW TOBACCO?	_____
USE DRUGS?	_____	_____			DRINK ALCOHOL?	_____

REFRACTION FEE

BY SIGNING BELOW, I UNDERSTAND THAT THERE IS A \$25.00 CHARGE FOR THE REFRACTION TEST. IN THE EVENT YOU LATER REQUEST A GLASSES PRESCRIPTION AND DID NOT PAY THE \$25.00 FEE AT THE TIME OF SERVICE YOU WILL BE RESPONSIBLE FOR THE \$25.00 AT THAT TIME.

SIGNATURE _____ DATE _____

PARENTAL CONSENT FOR THE TREATMENT OF A MINOR

PLEASE BE ADVISED THAT ANYONE SEEKING MEDICAL TREATMENT OR ROUTINE EYE CARE UNDER THE AGE OF 19 IS REQUIRED TO HAVE PARENTAL CONSENT. THIS CONSENT MUST BE GIVEN BY A PARENT OR LEGAL GUARDIAN. YOUR SIGNATURE BELOW GIVES US CONSENT TO PROVIDE THE NECESSARY MEDICAL CARE AND/OR VISION CARE DEEMED NECESSARY BY THE PHYSICIAN. ADDITIONALLY, YOU ARE ACCEPTING FINANCIAL RESPONSIBILITY FOR THIS CHILD AND ALL CO-PAYS AND/OR FEES FOR SERVICES/TREATMENT.

GUARANTOR'S SIGNATURE _____ DATE OF BIRTH _____