DATE: ____________ **The EyeCenter** 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

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

____________	____________	____________

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 $35.00 CHARGE FOR THE REFRACTION TEST. IN THE EVENT YOU LATER REQUEST A GLASSES PRESCRIPTION AND DID NOT PAY THE $35.00 FEE AT THE TIME OF SERVICE YOU WILL BE RESPONSIBLE FOR THE $35.00 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 PHYSICAN. ADDITIONALLY, YOU ARE ACCEPTING FINANCIAL RESPONSIBITY FOR THIS CHILD AND ALL CO-PAYS AND/OR FEES FOR SERVICES/TREATMENT.

GUARANTOR'S SIGNATURE ________________________________ DATE OF BIRTH ________________