

Welcome to our office. Thank you for completing the following medical history questionnaire.

(Mr., Mrs., Ms., Dr.)

Name _____ Parents (if minor) _____
 Address _____ City _____ State _____ Zip _____
 Email address _____ Home Phone _____ Work Phone _____
 Social Security # _____ - _____ - _____ Birth Date _____ / _____ / _____
 Last Eye Exam _____ Currently wearing? Glasses / Contact Lenses / Both / Neither Interested in Contact Lenses Y N Maybe
 Whom may we thank for referring you to our office? _____

Medical History

List any medication you take currently (including aspirin, oral contraceptives, and over the counter medications)

Are you allergic to any medications? No _____ Yes _____ If yes, please list _____
 Are you a pregnant or nursing mother? No _____ Yes _____ Maybe _____

Social History

Occupation / School _____ Employer / Grade _____
 Do you use tobacco products? No ___ Yes ___ Do you have a history of alcohol or substance abuse? No ___ Yes ___

Review of Systems

Do you currently, or have you ever had any problems in the following areas?

	Yes	No	If yes, please explain
Fever, Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid or other gland problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies / Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry throat / mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart or vasculature disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach or digestive problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney / Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle or joint pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus / Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other conditions not listed	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please turn this form over and complete side two

Current Eye Health

Do you currently, or have you ever had? (please circle all that apply)

eye injury eye infection glaucoma retinal disease cataracts crossed eyes lazy eye

Do you have any problems in the following areas with your primary vision correction? (For example with your glasses, contacts, or neither.)

	Yes	No	If yes, please explain
Blurring at distance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurring at near	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Night vision problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye discomfort or pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucus or mattering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing/ watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spots floating	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes of light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Twinkling lights	<input type="checkbox"/>	<input type="checkbox"/>	_____
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family History

Do any of your family members (parents, grandparents, brothers, sisters, children: living or deceased) have the following conditions:

	Yes	No	Relationship to you
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment / disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eyes / lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

Payment / Insurance Information

Please understand payment is due at the time of purchases or services and/or materials ordered.

Please circle method of payment: cash check insurance credit card [type of credit card:_____]

Please fill out the following insurance information (we will need to get a **copy** of your insurance card):

Insurance company_____ Member's name_____

Member's number_____ Member's employer_____

Please list any family members / friends that you would like your health information released to:

Patient Signature **Required** (If minor, Guardian's signature)

Date