

Medical History Questionnaire

Name: _____ Male/Female Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

Birth Date: ____/____/____ Social Security #: ____/____/____ E Mail: _____

Occupation _____ Last Eye Exam: ____/____/____

Name of Medical Doctor: _____ Last Medical Exam: _____

Vision Insurance: _____ Medical Insurance: _____

Who referred you to our office? _____

PLEASE LIST THE NAME AND SOCIAL SECURITY NUMBER OF THE PERSON WHO CARRIES THE VISION/MEDICAL INS.

Name: _____ SS#: ____/____/____ D.O.B.: ____/____/____

*****We must have all information in order to file your insurance for any dependants*****

Address _____ Phone _____

Who is responsible for this bill? _____

All co-pays are due at the time of your visit. Will you be paying by cash, check or credit card? _____

Medical History

Do you have any allergies to medications? No yes If yes, explain _____

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

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

Are you pregnant and/or nursing? No Yes

Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? Yes No

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

*** PLEASE TURN FORM OVER AND COMPLETE SIDE TWO***

Social History *This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.*

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes If yes, please describe:

Do you use tobacco products? No Yes If yes, type / amount / how long: _____

Do you drink alcohol? No Yes If yes, type / amount / how long: _____

Do you use illegal drugs? No Yes If yes, type / amount / how long: _____

How many hours per day do you spend on the computer? _____ Do you play any sports? _____

Do you do any close work? (ie. sewing, crafts, scrapbooking, needlework) _____

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (please check boxes)

SYSTEM	NO	YES	?	NO	YES	?
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT		
Fever, Weight Loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
EYES				RESPIRATORY		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARDIOVASCULAR		
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY		
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS/ MUSCLES		
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC		
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid / Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC / IMMUNOLOGIC		
				PSYCHIATRIC		
					<input type="checkbox"/>	<input type="checkbox"/>

***** I AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES AND MATERIALS RENDERED. I ALSO UNDERSTAND THAT IF MY INSURANCE COMPANY HAS NOT REIMBURSED THIS OFFICE WITHIN 60 DAYS IT IS MY RESPONSIBILITY TO PAY THE BALANCE IN FULL.**

SIGNATURE _____ **DATE** _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was given the opportunity/received a copy of GREENE COUNTY EYE CARE, INC notice of privacy policy.

SIGNATURE _____ **DATE** _____