Medical History Questionnaire

Mr. Mrs. Ms. _____ Today's Date _____
E-mail _____ Last Eye Exam _____ Date of Birth _____
Employer _____ Occupation _____

Describe how you use your vision at work so we can make the best lens recommendations for you:

_____

_____

What kinds of hobbies, sports, and other interests do you have? Knowing this enables us to find the best vision correction for you:

_____

Who can we thank for referring you to our office? _____

Your Personal History

Yes No

☐ ☐ Do you wear contacts? Type/Brand _____
☐ ☐ Are you pregnant or nursing?
☐ ☐ Have you had any major injuries, surgeries and/or hospitalizations? Please list them:

_____

☐ ☐ Do you take any medications? Please list them:

_____

Do you currently have or had the following conditions, check those that apply:

Allergic/Immunologic
☐ Drug Allergy _____
☐ Environmental Allergy _____
☐ Rheumatoid Arthritis

Cardiovascular
☐ Heart Disease
☐ Hypertension
☐ Stroke

General Health
☐ Developmental Disability
☐ Head Trauma
☐ Headaches
☐ Cancer

Ears, Nose Throat
☐ _____

Endocrine
☐ Diabetes
☐ Thyroid

Neurological
☐ Multiple Sclerosis
☐ Epilepsy

Respiratory
☐ Asthma
☐ Emphysema

Eyes
☐ Retinal Detachment
☐ Glaucoma
☐ Cataracts
☐ Macular Degeneration
☐ Lazy Eye
☐ Eye Infections
☐ Eye Injury

Genitourinary
☐ STD - HIV, Herpes, Chlamydia

Hematologic/Lymphatic
☐ Anemia
☐ Leukemia

Dermatologic
☐ Eczema
☐ Rosacea
☐ Psoriasis

Muskuloskeletal
☐ Muscular Dystrophy
☐ Osteoarthritis
☐ Ankylosing Spondylitis

Psychiatric
☐ Depression

☐ **Gastrointestinal**

Continued on other side

Family History

Does any family member (parents, grandparents, siblings, children) currently have or had any of the following conditions? Please write the relationship to you.

- ☐ Blindness _____
- ☐ Cataract _____
- ☐ Crossed Eyes _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Retinal Detachment/Disease _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Thyroid Disease _____
- ☐ Other: _____

Health History Update

Changes in medical history? Yes	No	List Changes	Date	Patient Initials
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			

Payment Policy:

We will do all we can to find out what your vision insurance benefits are and what you are eligible for. We will also submit your claim for you. The information given to us by your insurance company is not a guarantee of payment from them. If your insurance company does not pay this amount it will be your responsibility to pay your balance.

To the best of my knowledge, the above information is correct.

_____ _____

Patient's signature or Parent/Guardian Date