

# Medical History Questionnaire

\* IN ORDER FOR YOUR INSURANCE COMPANY TO BE BILLED, THIS FORM MUST BE FILLED OUT COMPLETELY (FRONT & BACK)\*

Patient's Name: \_\_\_\_\_ Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's Name: \_\_\_\_\_ Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dependent's Name(s): \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Race: \_\_\_\_\_

\_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Email Address: \_\_\_\_\_

Preferred Contact Method: (Please check)  Home  Cell  Text  Email Occupation: \_\_\_\_\_

Patient's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Vision Insurance: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 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 all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

Circle any of the following that you have had: Crossed Eyes, Lazy Eye, Drooping Eyelid, Prominent Eyes, Glaucoma, Retinal Disease, Cataracts, Eye Infections.

Are you pregnant and/or nursing?  No  Yes

### 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"/>	_____
Crossed Eyes	<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"/>	_____
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 _____				_____

### Do you.....

	No	Yes
...work at a computer for long periods?	<input type="checkbox"/>	<input type="checkbox"/>
...wear more than one pair of glasses?	<input type="checkbox"/>	<input type="checkbox"/>
...want information on thinner, lighter lenses?	<input type="checkbox"/>	<input type="checkbox"/>
...wear Bifocals?	<input type="checkbox"/>	<input type="checkbox"/>
...(If yes, are you bothered by head tilting, restricted areas of vision correction, etc??)	<input type="checkbox"/>	<input type="checkbox"/>
...always like to wear your glasses?	<input type="checkbox"/>	<input type="checkbox"/>
...spend time outdoors? (how much?)	<input type="checkbox"/>	<input type="checkbox"/>
...have prescription sunglasses?	<input type="checkbox"/>	<input type="checkbox"/>
...have problems with glare or reflection particularly when driving at night?	<input type="checkbox"/>	<input type="checkbox"/>
...have you ever worn/are currently wearing contacts?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Are you planning on getting new contacts today?	<input type="checkbox"/>	<input type="checkbox"/>
Are you planning on getting new glasses today?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like information on Lasik Correction?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in having Lasik Correction?	<input type="checkbox"/>	<input type="checkbox"/>