Medical History Questionnaire

Name: _____ Today's Date: _____

Address: _____ Phone: _____

_____ Work Phone: _____

Guardian (If Applicable): _____ Occupation: _____

Email: _____ Preferred Language: _____

Birth Date: _____ Social Security #: _____ Race/Ethnicity: _____

Gender: _____ Date of Last Eye Exam: _____ Date of Last Medical Exam: _____

Name of Medical Doctor: _____ Dr.'s Phone: _____

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: _____

_____

Check any of the following that you have had: ❒ crossed eyes ❒ lazy eye ❒ drooping eyelid ❒ prominent eyes

❒ Glaucoma ❒ retinal disease ❒ cataracts ❒ eye infections ❒ eye injury

Are you pregnant 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: note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions.

Disease/Condition	No	Yes	?	Relationship To You
Blindness	❒	❒	❒	
Cataract	❒	❒	❒	
Crossed Eyes	❒	❒	❒	
Glaucoma	❒	❒	❒	
Macular Degeneration	❒	❒	❒	
Retinal Detachment or Disease	❒	❒	❒	
Arthritis	❒	❒	❒	

Disease/Condition	No	Yes	?	Relationship To You
Cancer	❒	❒	❒	
Diabetes	❒	❒	❒	
Heart Disease	❒	❒	❒	
High Blood Pressure	❒	❒	❒	
Kidney Disease	❒	❒	❒	
Lupus	❒	❒	❒	
Thyroid Disease	❒	❒	❒	
Other: _____				

✳ *Please Turn This Form Over & Complete Side Two* ✳

Social History: *This information is kept strictly confidential. You may discuss this portion directly 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: _____

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

Review of Systems: Do you currently, or have you ever had any problems in the following areas?

System	NO	YES	?
Constitutional			
Fever, Weight Loss/Gain	❒	❒	❒
Integumentary (Skin)	❒	❒	❒
Neurological			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
Eyes			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection, Eye or Lid	❒	❒	❒
Sties or Chalazion	❒	❒	❒
Flashes/Floaters in Vision	❒	❒	❒
Tired Eyes	❒	❒	❒
Endocrine			
Thyroid/Other Glands	❒	❒	❒

System	NO	YES	?
Ears, Nose, Mouth, Throat			
Allergies/Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
Respiratory			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
Vascular / Cardiovascular			
Diabetes	❒	❒	❒
Heart Pain	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
Gastrointestinal			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
Genitourinary			
Genitals/Kidney/Bladder	❒	❒	❒
Bones / Joints / Muscles			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
Lymphatic / Hematologic			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
Allergic / Immunologic	❒	❒	❒
Psychiatric	❒	❒	❒

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

_____

_____ _____

Doctor's Signature Date

Insurance Information

PATIENT NAME_____ DATE OF BIRTH_____

MAILING ADDRESS_____

CITY_____ STATE_____ ZIP_____-_____

SOCIAL SECURITY NUMBER_____ SEX (M OR F)

HOME TELEPHONE_____ CELL PHONE_____ WORK TELEPHONE_____

RACE_____ ETHNIC GROUP_____

EMAIL ADDRESS_____

PREFERRED APPOINTMENT CONFIRMATION_____ PHONE_____ EMAIL_____ TEXT MESSAGE _____

INSURED'S NAME_____ DATE OF BIRTH_____

INSURED'S SOCIAL SECURITY NUMBER_____

NAME OF INSURANCE_____ ID#_____

RESPONSIBLE PARTY_____ SSN_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____-_____

EMAIL ADDRESS (IF DIFFERENT FROM ABOVE)_____

PLACE OF EMPLOYMENT_____

WORK PHONE NUMBER_____ CELL PHONE NUMBER_____

I certify that all information is complete and authorized the release of my medical information necessary to process insurance claims including HCFA and the payment of medical benefits to myself or the party who accepts assignments. This does include authorization to file through Medigap Program. I authorize the release of my records to health care providers for the purpose of patient care. I consent for any clinical tests to be performed that are deemed necessary by my doctor and I received information regarding the HIPPA privacy regulations.

SIGNATURE_____ DATE_____

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Family Vision Clinic, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Family Vision Clinic, Inc.'s Notice of Privacy Practice and agree to continue my care with Family Vision Clinic, Inc. under said terms.
- ☐ I have read or had explained to me Family Vision Clinic, Inc.'s Notice of Privacy Practice and do not wish to continue my care with Family Vision Clinic, Inc. under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as
- ☐ Knowing that standard email and text communication may not be totally secure, I still consent to communications from my doctor or staff through my standard email and texting devices.

_____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient