Medical History Questionnaire

PLEASE PRINT

Name: _____ Mr. / Mrs. / Ms. Today's Date: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____ email: _____

Home Phone: _____-_____-_____ Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____
How would you like to be reminded about your next appointment? □Mail □Email □Cell Phone □ Home Phone □Work Phone

Birth Date: ____/____/____ Age: ____ Sex: M___ F___ Marital Status: Single___ Married___ Widowed____

Referred By: _____ Occupation: _____ Social Security #: _____

Have you ever been examined in this office? No___ Yes___ Date of last eye exam: _____
Do you have vision insurance? No___ Yes___ Name of Insurance Carrier:_____
Do you have health insurance? No___ Yes___ Name of Insurance Carrier:_____
Do you have Secondary health insurance? No___ Yes___ Name of insurance Carrier:_____

Are you pregnant and / or nursing? No ___ Yes ___
Do you wear glasses? No ___ Yes ___ If yes, what type? _____
Do you wear contact lenses? No ___ Yes ___ If yes, what type? _____
Do you smoke? No ___ Yes ___

MEDICAL HISTORY

Please list <u>all</u> medications you are currently taking (including oral contraceptives and over-the-counter medications):
_____
_____
_____

Do you have any allergies? No ___ Yes ___ If yes, describe: _____
_____

Please list any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, bulging eyes, glaucoma, retinal disease, cataracts, eye infections, eye injury or surgery (including Lasik and PRK) : _____
_____
_____

HEALTH HISTORY

Do you or anyone in your <u>immediate</u> family (parents, grandparents, brothers, sisters or children) have the following:

DISEASE / CONDITION	NO	YES	SELF	FAMILY	RELATIONSHIP TO YOU
Cataracts	___	___	___	___	_____
Glaucoma	___	___	___	___	_____
Macular Degeneration	___	___	___	___	_____
Retinal Detachment / Disease	___	___	___	___	_____
Crossed Eyes	___	___	___	___	_____
Dry Eyes	___	___	___	___	_____
High Blood Pressure	___	___	___	___	_____
Diabetes	___	___	___	___	_____
Thyroid Problems	___	___	___	___	_____
Headaches / Migraines	___	___	___	___	_____
Asthma / Emphysema	___	___	___	___	_____
Arthritis	___	___	___	___	_____
Other	___	___	___	___	_____

Signature: Patient: _____ Doctor: _____ Date: _____