Personal and Medical History Questionnaire

Name ____ Today's Date _____/_____/________
first mi last

Address ____ Home Phone ____________________
street

____ Cell Phone ____________________
city state zip

May we send you text message reminders? Y N

Birthday _____/_____/_____ Social Security # _____-_____-_____ Work Phone ____________________

Preferred method of contact:
home cell work email

Email ____

Sex/Identify as: Male Female Unknown FTM MTF Neither Choose to not disclose

Parent/Guardian (if minor) ______________________________ Preferred Language _______________

Employer/Occupation ______________________________ School/Grade ____________________

Insurance Information

Primary Vision ______________________ Policy holder ______________________ DOB___/___/______

Policy holder employer __________________ Insured ID# ________________ Last 4 SSN (policy holder) ______

Secondary Vision ______________________ Policy holder ______________________ DOB___/___/______

Policy holder employer __________________ Insured ID# ________________ Last 4 SSN (policy holder) ______

Primary Medical ______________________ Policy holder ________________________________

Insured ID# ______________________________ Group ID# ________________________________

Medical History

Name of Medical Doctor ________________________________ Last medical exam ____/____/_______

Do you have any allergies to medications? yes no If yes, explain ______________________________

List any medications you take (include oral contraceptives, aspirin and over the counter medications)

____

____

Previous Hospitalizations/Surgeries/Serious Illnesses When?

____ ____________________

____ ____________________

Do you wear glasses? no yes If yes, how old is your present pair of lenses? ____________________

Do you wear contacts? no yes If yes, how old is your present pair of lenses? ____________________

Type of contact lenses Rigid Soft Do you sleep in contacts? no yes Are they comfortable? no yes

Would you like to talk to the doctor about the possibility of LASIK surgery? no yes

Family Ocular and Medical History

Please check the box if any parents, siblings, children; living or deceased has or had the following conditions:

Amblyopia (lazy eye)	Arthritis	Heart Disease
Cataract	Cancer	Lupus
Glaucoma	Diabetes	Migraine Headaches
Iritis	Hypertension (blood pressure)	Multiple Sclerosis
Macular Degeneration	Hyper/Hypo Thyroid Disease	
Strabismus (crossed eyes)		

Please complete backside of page

Personal and Past Ocular History

Diabetic Retinopathy
Flashes of light or floaters
Iritis or Uveitis
Glaucoma
Glaucoma Suspect
Cataract
Age-related Macular Degeneration
Surgery
Strabismus (crossed eyes)
Amblyopia (lazy eye)
Retinal Detachment or defect
Keratoconus
Injury
Dry Eye

Social History

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

I would prefer to discuss my Social History information directly with my doctor. (check box)

Use of Alcohol:

Never
Rarely
Moderate
Daily

Use of Tobacco:

Smokes Cigarettes
Smokes Cigars
Smokes Pipe
Smokes Other
Smokeless Tobacco

Smoking Status:

Non-smoker
Former smoker
Current someday smoker
Current everyday smoker

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes

If yes, please explain:____

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

Constitutional

- ❑ Developmental disability
- ❑ Cancer
- ❑ Fatigue
- ❑ Other ______________

Ear, Nose and Throat

- ❑ Dry Mouth
- ❑ Hearing loss
- ❑ Sinusitis
- ❑ Laryngitis
- ❑ Other ______________

Neurological

- ❑ Multiple Sclerosis
- ❑ Epliepsy
- ❑ Cerebral Palsy
- ❑ Tumor
- ❑ Stroke/CVA
- ❑ Migraine
- ❑ Autism Spectrum
- ❑ Other______________

Psychiatric

- ❑ Depression
- ❑ Attention Deficit
- ❑ Anxiety Disorder
- ❑ Bipolar
- ❑ Other _______________

Cardiovascular

- ❑ Stroke
- ❑ Heart Disease
- ❑ Hypertension
- ❑ Vascular disease
- ❑ Congenital Heart Failure
- ❑ Other________________

Respiratory

- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Chronic Obstruction
- ❑ Sleep Apnea
- ❑ Other _______________

Gastrointestinal

- ❑ Crohn's
- ❑ Colitis
- ❑ Ulcer
- ❑ Acid Reflux
- ❑ Celiac Disease
- ❑ Other _______________

Genitourinary

- ❑ STD, Viral Herpetic, Chlamydia
- ❑ Herpes
- ❑ Benign Prostate Hypertrophy
- ❑ Kidney Disease
- ❑ Pregnant (currently)
- ❑ Nursing (currently)
- ❑ Other _____________

Musculoskeletal

- ❑ Fibromyalgia
- ❑ Muscular dystrophy
- ❑ Osteoarthritis
- ❑ Ankylosing spondylitis
- ❑ Osteoporosis
- ❑ Arthritis
- ❑ Gout
- ❑ Other______________

Integumentary

- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Herpes Simple (cold sores)
- ❑ Herpes Zoster (shingles)
- ❑ Other _____________

Endocrine

- ❑ Non-insulin dependent diabetes (type 2)
- ❑ Insulin dependent diabetes (type 1)
- ❑ Thyroid dysfunction
- ❑ Hormonal dysfuntion
- ❑ Other_____________

Hematologic/Lymph

- ❑ Anemia
- ❑ Large volume blood loss
- ❑ Ulcer
- ❑ Hypercholesteremia
- ❑ Other_____________

Allergic/Immunologic

- ❑ Drug Allergy
- ❑ Enviromental Allergy
- ❑ Rheumatoid Arthritis
- ❑ Lupus
- ❑ Sjogren's Syndrome
- ❑ Other ____________

If you have a condition not listed, please explain.

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____________________________________ Signature of Doctor

_______________ Date