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 _________________

Email ______________________________________ Last vision exam ___________________

Preferred Language______________ Preferred method of contact: □ home phone □ work □ cell □ email

Please indicate the group you most closely identify with: □ Hispanic or Latino □ Caucasian □ Asian
□ American Indian or Alaska Native □ African American □ Pacific Islander

Occupation ______________________________ Employer ____________________________________

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

Insurance Information

Primary **Vision** insurance company ________________________ Insured ID # ________________

Name of insured _______________________________ Relationship to patient ___________________

Secondary **Vision** insurance company ______________________ Insured ID # ________________

Secondary insured name __________________________ Relationship to patient ___________________

Medical insurance company ______________________________ Insured 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)

____

____

____

Are you pregnant and/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 Do you sleep in contacts? ❑yes ❑no Are they comfortable? ❑ yes ❑ no

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

Personal and Family History

Please circle self, family or both (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/condition		**Disease/condition**	
Glaucoma	self / family	High blood pressure	self / family
Cataract	self / family	Diabetes	self / family
Macular degeneration	self / family	Heart disease	self / family
Blindness	self / family	Cancer	self / family
Retinal detachment	self / family	Thyroid disease	self / family
Strabismus (crossed eyes)	self / family	Lupus	self / family
Amblyopia (lazy eye)	self / family	Arthritis	self / family
Iritis	self / family	Migraine headaches	self / family
Dry eyes	self / family	Multiple sclerosis	self / family

Previous Hospitalizations/Surgeries/Serious Illnesses When?

______________________________ ______________

______________________________ ______________

______________________________ ______________

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)

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

____

Use of Alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily

Have you been exposed or infected with: ❑ Hepatitis ❑ HIV ❑ STD

Review of Systems

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

Allergic/Immunologic
- ❑ Drug Allergy
- ❑ Environmental allergy
- ❑ Rheumatoid arthritis
- ❑ Lupus
- ❑ Other ____________

Gastrointestinal
- ❑ Crohn's
- ❑ Colitis
- ❑ Ulcer
- ❑ Digestive issues
- ❑ Other ____________

Psychiatric
- ❑ Depression
- ❑ Panic disorder
- ❑ Schizophrenia
- ❑ Other ____________

Endocrine
- ❑ Non-insulin dependent diabetes
- ❑ Insulin dependent diabetes
- ❑ Thyroid dysfunction
- ❑ Hormonal dysfunction
- ❑ Other ____________

Eyes
- ❑ Glaucoma
- ❑ Cataract
- ❑ Macular Degeneration
- ❑ Surgery
- ❑ Inflammatory disorders
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Other ____________

Neurological
- ❑ Multiple Sclerosis
- ❑ Epilepsy
- ❑ Alzheimer's
- ❑ Parkinson's
- ❑ Cerebrovascular
- ❑ Other ____________

Ear, Nose, Mouth & Throat
- ❑ Upper respiratory tract infection
- ❑ Ear ache
- ❑ Runny nose
- ❑ Sore throat
- ❑ Ringing/Tinnitus
- ❑ Other ____________

Musculoskeletal
- ❑ Fibromyalgia
- ❑ Muscular dystrophy
- ❑ Osteoarthritis
- ❑ Ankylosing spondylitis
- ❑ Other ____________

Constitutional
- ❑ Developmental disability
- ❑ Weight loss
- ❑ Fever
- ❑ Fatigue
- ❑ Trauma
- ❑ Other ____________

Hematologic/Lumphatic
- ❑ Anemia
- ❑ Large volume blood loss
- ❑ Leukemia
- ❑ Other ____________

Integumentary
- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Other __________

Cardiovascular
- ❑ Heart Disease
- ❑ Hypertension
- ❑ Stroke
- ❑ Vascular disease
- ❑ High Cholesterol

Genitourinary
- ❑ STD, Viral Herpetic, Chlamydia
- ❑ Other ___________

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Other

Smoking status:
- ❑ Non-smoker
- ❑ Former smoker
- ❑ Current

If you have a condition not listed, please explain.

____

____

______________________________ ______________

Signature of Doctor Date