MEDICAL HISTORY QUESTIONNAIRE

Welcome to Eye Site Vision Care Center! To better serve your eye care needs, we request that you complete this medical history form. Thank you.

Last Name _____ First Name _____ M.I. _____ Today's date _____/_____/_____

Street Address _____ City _____ Zip _____

Daytime Phone (_____) _____-_____ Cell Phone (_____) _____-_____ **Email Address** _____

S.S.N. XXX-XX-_____ D.O.B. ____/____/____ Gender: M / F Parent/Guardian Name (if minor) _____

Occupation/School Grade (if minor) _____ Employer _____

Spouse's Name _____ Who is responsible for payment of services rendered? _____

Physician _____ Health Insurance and Policy # _____

Date of last eye exam _____ Vision Insurance and Policy # _____

Do you feel that your eyes are changing? Yes No Do you have questions about laser refractive surgery? Yes No

Do you currently wear contact lenses? Yes No If yes, what type? Soft Disposable or Rigid Gas Permeable

Do you experience any of the following currently with your vision (please circle): Blurred distance, Blurred near, Burning, Itchiness, Headaches, Tearing, Dryness, Eye Strain, Reading problems, Floaters/Spots, Soreness, Flashes of Light, Redness, Double vision, Sudden loss of vision, or Sensitivity to light

How did you hear of our office (please circle)? Friend/Relative (who?) _____ Insurance Other

List ALL medications that you are currently taking (including oral contraceptives, over the counter medications, vitamins, home remedies, or eye drops):

_____

_____

List any medications that you have had an allergic reaction to: _____

Tobacco Use: Yes No How long? _____

Alcohol Use: Yes No How often? _____

EYE HISTORY:
Do you have, or have you had in the past any of the following:

Glaucoma	Yes No	Eye Injury	Yes No
Eye Surgery	Yes No	Cataracts	Yes No
Eye Infection	Yes No	Lazy Eye	Yes No
Eye Disease	Yes No	Other_____	

FAMILY HISTORY:	(RELATIONSHIP)
Glaucoma	Yes No _____
Cataracts	Yes No _____
Diabetes	Yes No _____
Hypertension	Yes No _____
Lazy Eye	Yes No _____
Macular Degeneration	Yes No _____
Other eye problems	_____

Code Past, Family and Social History: NEW Pertinent (1-2 Areas reviewed) Complete (3 areas reviewed): ESTABLISHED Pertinent (1 area), Complete (2-3 areas)

REVIEW OF SYSTEMS: Please indicate your history below (if normal, circle NONE)

Immune/Allergy
Y N Environmental Allergy
Y N Rheumatoid Arthritis
Y N Lupus
Y N Other
NONE

Respiratory
Y N Asthma
Y N Bronchitis
Y N Emphysema
Y N Other
NONE

Blood/Lymph
Y N Anemia
Y N Large Blood Loss
Y N Bleeding Disorder
Y N Other
NONE

Ear/Nose/Throat
Y N Sinus
Y N Hearing Loss
Y N Sore Throat
Y N Other
NONE

Endocrine
Y N Diabetes
Y N Thyroid
Y N Menopause
Y N Other
NONE

Constitutional
Y N Good General Health
Y N Recent Weight Change
Y N Fever/Fatigue
Y N Other
NONE

Cardiovascular
Y N Heart Disease
Y N High Blood Pressure
Y N Stroke
Y N Other
NONE

Nervous System
Y N Multiple Sclerosis
Y N Head Injury
Y N Seizures/Convulsions
Y N Other
NONE

Genitourinary
Y N Kidney Problems
Y N Prostate
Y N Other
NONE

Musculoskeletal
Y N Osteoarthritis
Y N Fibromyalgia
Y N Cold Extremities
Y N Other
NONE

Psychiatric
Y N Depression
Y N Memory Loss/Confusion
Y N Schizophrenia
Y N Other
NONE

Other
Y N Cancer
Y N Developmental Disorder
Y N Loss of Consciousness
Y N Other
NONE

Skin
Y N Eczema
Y N Rosacea
Y N Psoriasis
Y N Other
NONE

Gastrointestinal
Y N Colitis/Crohn's
Y N Ulcers
Y N Reflux
Y N Other
NONE

Code Review of Systems 1 Problem Pertinent 2-9 Extended 10-14 Complete Doctor's Initials_____