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	none	High blood pressure	none
Cataract	none	Diabetes	none
Macular degeneration	none	Heart disease	none
Blindness	none	Cancer	none
Retinal detachment	none	Thyroid disease	none
Strabismus (crossed eyes)	none	Lupus	none
Amblyopia (lazy eye)	none	Arthritis	none
Iritis	none	Migraine headaches	none
Dry eyes	none	Multiple sclerosis	none

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