MEDICAL HISTORY QUESTIONNAIRE Date_____

Name M or F Date of Birth Social Security #

Address City/State/Zip Email Address

Phone Alternate phone (work , cell) Date of Last Eye Exam and Drs. Name

Date of last Medical exam Name of Medical Dr and Phone #

Single ☐ Married ☐ _____
Spouses name, or person to contact in case of emergency

How did you hear about us?_____

Primary Insurance Member Name Member ID# Group#

Members address Members Phone Members Date of Birth

Members Employer

Secondary Insurance_____ _____
Member name and Address. Date of Birth

Insurance ID# Group # Name of Plan Employer

Name of Parent or Guardian (if under 18 years of age)

Medical History

Do you have any allergies to medications? □No □Yes If yes, Explain:_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):_____

List all major injuries, surgeries and/ or hospitalizations you have had:_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injury:_____

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 □ Extended Wear □ Other Are they comfortable? □ yes □ no

Family History

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

Disease/Condition	No	Yes	?	Relationship to you
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____

Disease/Condition	No	Yes	?	Relationship to you
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other_____	☐	☐	☐	_____

Review of Systems

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

Eyes

Loss of Vision	☐ no ☐ yes ☐ ?	Blurred Vision	☐ no ☐ yes ☐ ?
Distorted Vision / Halos	☐ no ☐ yes ☐	Double Vision	☐ no ☐ yes ☐ ?
Dryness	☐ no ☐ yes ☐ ?	Mucous Discharge	☐ no ☐ yes ☐ ?
Redness	☐ no ☐ yes ☐ ?	Sandy or Gritty Feeling	☐ no ☐ yes ☐ ?
Itching	☐ no ☐ yes ☐ ?	Burning	☐ no ☐ yes ☐ ?
Foreign Body Sensation	☐ no ☐ yes ☐ ?	Excess Tearing / Watering	☐ no ☐ yes ☐ ?
Glare / Light Sensitivity	☐ no ☐ yes ☐ ?	Eye Pain or Soreness	☐ no ☐ yes ☐ ?
Chronic Infection of eye/ Lid	☐ no ☐ yes ☐ ?	Sties or Chalazion	☐ no ☐ yes ☐ ?
Flashes / Floaters in Vision	☐ no ☐ yes ☐ ?	Tired Eyes	☐ no ☐ yes ☐ ?

Allergic / Immunologic ☐ no ☐ yes ☐ ?

If you answered YES to any of the above or have a condition not listed, please explain :_____

_____

_____

Reviewing Dr.'s Signature_____ Date_____

Release to file insurance and acknowledgement of receipt of privacy policy

I understand that professional fees are due at the time services are rendered and that a 50% deposit is required at time of order on all materials. Orders will be held for a maximum of 45 days. After this time all orders will be returned to the lab and the deposit will be forfeited and not refunded.

I understand and agree that insurance payments are an arrangement between my insurance carrier and myself. I authorize this office to prepare any insurance forms to assist me in reimbursement from my insurance company. I authorize that payment be made directly to this office and be credited to my account upon receipt. I authorize this office to release any information required to process any insurance claims.

X Signature_____ Date _____