

Medical History Questionnaire

PLEASE FILL OUT BOTH SIDES

PLEASE USE YOUR LEGAL NAME AS IT APPEARS ON YOUR INSURANCE CARD

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

Home Phone: _____

City/State/Zip _____

Cell Phone: _____ Age: _____

Birth Date: ___/___/___ Social Security #: ___/___/___

Date of Last eye exam: _____

Employment: _____

Work phone: _____

Spouse's name: _____

Spouse's Employment: _____

If Minor, Parent's name: _____

Insurance Information:

Company: _____

ID # _____

I UNDERSTAND I WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

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 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

Medical Doctors name: _____ Phone: _____

Date of last exam: _____ General Health: _____ Date of last tetanus shot: _____

HIPAA PRIVACY POLICY INFORMATION

A COPY OF ABBEY EYE CARE'S NOTICE OF PRIVACY PRACTICES IS AVAILABLE FOR YOUR REVIEW, OR IF YOU WISH A COPY CAN BE MADE FOR YOU. PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE BEEN MADE AWARE OF THE PRIVACY POLICY.

SIGNATURE _____

MINOR'S NAME _____

Family History

DISEASE/CONDITION	YES	NO	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Review of Systems

SYSTEMIC REVIEW

	YES	NO
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Fainting, Seizures, Stroke	<input type="checkbox"/>	<input type="checkbox"/>

EYES AND VISION

Flashes/floaters in vision	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Vision Loss	<input type="checkbox"/>	<input type="checkbox"/>
Vision blurred	<input type="checkbox"/>	<input type="checkbox"/>
Distorted/halos	<input type="checkbox"/>	<input type="checkbox"/>
Side vision loss	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Sandy Feeling	<input type="checkbox"/>	<input type="checkbox"/>
Eyes Itch	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>
Burning Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>
Infection of Eyes or Lids	<input type="checkbox"/>	<input type="checkbox"/>
Sties/Chalazion	<input type="checkbox"/>	<input type="checkbox"/>

HEAD, EARS, NOSE, MOUTH, THROAT

	YES	NO
Allergies/Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>
Dryness of throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>

LUNGS

Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR

Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>

GIS

Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>

MUSCLES AND JOINTS

Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Muscle soreness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Soreness	<input type="checkbox"/>	<input type="checkbox"/>

IMMUNOLOGIC

	<input type="checkbox"/>	<input type="checkbox"/>
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PSYCHIATRIC

	<input type="checkbox"/>	<input type="checkbox"/>
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ENDOCRINE

Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

Employed? Fulltime Part-time Not employed
 Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No

Describe driving problems: _____

Computer Usage: Yes No Hours per day? _____

Tobacco Products? Yes No How long and quantity: _____

Alcoholic drinks? Yes No How long and quantity: _____

Psychological drugs? Yes No How long and quantity: _____

Diseases: Gonorrhoea Hepatitis HIV Syphilis