Medical History Questionnaire — Vision Care Clinic, P.C.

Name: Mr., Mrs., or Ms., Miss._____ Today's Date _____
Address: _____ PO Box _____ Birth Date _____
City _____ State _____ Zip _____ S.S. # _____
Phone: (____)_____ Work #: _____ Employer: _____

Check one: Single _____ Married _____ Name of Parent/Guardian: _____
Spouse: _____ Birth Date: _____ Employer: _____
Contact Person:_____ Phone: (____)_____
Email Address: _____
Name of Medical Doctor: _____ Last Eye Exam: _____

Please supply the following information regarding your Healthcare Insurance:
Insured's Name: _____ Insured's Birth Date: _____ Employer: _____

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 and drops): _____

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/Disease	___	___	___	_____
Arthritis	___	___	___	_____
Cancer	___	___	___	_____
Diabetes	___	___	___	_____
Heart Disease	___	___	___	_____
High Blood Pressure	___	___	___	_____
Kidney Disease	___	___	___	_____
Lupus	___	___	___	_____
Thyroid Disease	___	___	___	_____
Other _____	___	___	___	_____

**** Please turn this form over and complete side two ****

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

_____ Yes, I would prefer to discuss my social History information directly with my doctor.

Do you drive? ___ No ___ Yes If yes, do you have visual difficulty when driving? _____ no _____ yes If yes, please describe:

_____

Do you use tobacco products? _____no _____ yes If yes, type/amount/how long: _____

Do you drink alcohol? _____ no _____ yes If yes, type/amount/how long: _____

Do you use illegal drugs? _____ no _____ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: _____ Gonorrhea _____ Hepatitis _____ HIV _____ Syphilis

Review of Systems

Do you have a chronic or current problem in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/G	☐	☐	☐
INTEGUMENTARY (skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision / Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing / Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of eye or lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid / Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat / Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

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

_____

_____

_____ Date: _____/_____/_____

Doctor's Signature

It is therefore clinic policy that **payment is due for professional services when provided**. A deposit of 50% is required for materials ordered and full balance due when dispensed. If other payment arrangements are necessary, do so in advance with our accounts manager. Medicare,Medicare supplements, Medicaid, and other insurance claims are submitted by our office as a service to our patients. Thank you for allowing Vision Care Clinic, P.C. to provide care for your sight. If you have read, answered properly, and understand the payment policy please sign:

X_____ Date: _____/_____/_____

Patient or Parent/Guardian