Medical History Questionnaire

*** IN ORDER FOR YOUR INSURANCE COMPANY TO BE BILLED, THIS FORM MUST BE FILLED OUT COMPLETELY (FRONT & BACK)***

Patient's Name: _____ Last Eye Exam: _____/_____/_____Today's Date: _____/_____/_____

Patient Social Security #: _____-_____-_____ Last Medical Exam: _____/_____/_____

Is Patient a Minor? ☐ No ☐ Yes DOB: ____/____/_____ Age: _____ Sex:☐ M ☐ F Race: _____

Spouse's Name: _____ Home Phone: __(_____)_____

Dependent's Name(s): _____ Mobile Phone: __(_____)_____

Address: _____ Email Address: _____

City _____ **State** _____ **Zip Code** _____ Occupation: _____

Preferred Contact Method: (Please check) ☐Home ☐Cell ☐Text ☐Email Work Phone: __(_____)_____

Health Insurance: _____ **Vision Insurance**: _____

Parent/Guardian/Policy Holder Name: _____ Parent/Guardian/Policy Holder Name:_____

Policy Number: _____ Policy Number: _____

Policy Holder Social Security #: _____-_____-_____ DOB: ___/___/_____ Policy Holder Social Security #: ____-____-_____ DOB: ___/____/_____

Medical History

Do you have any allergies to medications? ☐ No ☐ Yes If yes, please 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: _____

_____

Circle any of the following that you have had: Crossed Eyes, Lazy Eye, Drooping Eyelid, Prominent Eyes, Glaucoma, Retinal Disease, Cataracts, Eye Infections.

Are you pregnant and/or nursing? ☐ No ☐ Yes

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 _____				_____

Do you…..	No	Yes
…work at a computer for long periods?	☐	☐
…wear more than one pair of glasses?	☐	☐
…want information on thinner, lighter lenses?	☐	☐
...wear Bifocals?	☐	☐
…(If yes, are you bothered by head tilting,	☐	☐
restricted areas of vision correction, etc??)	☐	☐
…always like to wear your glasses?	☐	☐
…spend time outdoors? (how much?)	☐	☐
….have prescription sunglasses?	☐	☐
…have problems with glare or reflection	☐	☐
particularly when driving at night?	☐	☐
…have you ever worn/are currently wearing		
contacts?	☐	☐
Are you interested in contact lenses?	☐	☐
Are you planning on getting new contacts today?	☐	☐
Are you planning on getting new glasses today?	☐	☐
Would you like information on Lasik Correction?	☐	☐
Are you interested in having Lasik Correction?	☐	☐

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