

Medical History Questionnaire

Name: _____ Birth Date: _____ Today's Date: _____

PATIENT MEDICAL HISTORY

Name of Medical Doctor: _____ Town: _____ Date of Last Medical Exam: _____

Current Medications: (Prescription or Over the Counter) Please list the name of the medications including eye drops, vitamins and oral contraceptives: _____

Do you have allergies to medications? No Yes If so, what medications? _____

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

Mark any of the following you have had: Crossed eyes Lazy Eye Drooping Eyelid Prominent Eyes
 Glaucoma Retinal Disease Cataracts Eye Infections Eye Injury _____

Are you pregnant? No Yes Due Date (if known) _____ Are you nursing? No Yes

Date of Last Eye Exam: _____ By Whom? _____

Do you wear glasses? No Yes How old are your glasses? _____ Do you have a back up pair? No Yes

Do you currently wear contacts? No Yes What kind? _____ Solutions used? _____

How often do you replace your contacts? _____

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Corneal Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

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

Have you ever been diagnosed or treated for the following health problems?

EYES

Loss of Vision No Yes _____ (explain/medications)

Blurred Vision No Yes _____

Distorted Vision / Halos No Yes _____

Loss of Side Vision No Yes _____

Double Vision No Yes _____

Dryness No Yes _____

Eye Infections No Yes _____

Redness No Yes _____

Sandy Gritty Feeling No Yes _____

Itching No Yes _____

Burning No Yes _____

Excess Tearing / Watering No Yes _____

Glare / Light Sensitivity No Yes _____

Eye Pain or Soreness No Yes _____

Chronic Infection of Eye or Lid No Yes _____

Stye or Chalazion No Yes _____

Flashes of Lights No Yes _____

Floater in Vision No Yes _____

Tired Eyes No Yes _____

Cataracts No Yes _____

Crossed Eye / Turned Eye No Yes _____

Glaucoma No Yes _____

Macular Degeneration No Yes _____

Retinal Detachment No Yes _____

Corneal Abrasions No Yes _____

Eye Injury No Yes _____

Iritis / Uveitis No Yes _____

Lazy Eye No Yes _____

BONES / JOINTS / MUSCLES

Rheumatoid Arthritis No Yes _____

Muscle Pain No Yes _____

Joint Pain No Yes _____

PSYCHIATRIC

Memory Loss No Yes _____

Depression No Yes _____

Panic Attack / Anxious Tendencies No Yes _____

CONSTITUTIONAL

Fever, Weight Loss / Gain No Yes _____ (explain/medications)

Chronic Fatigue No Yes _____

INTEGUMENTARY (Skin)

Eczema / Rashes / Moles No Yes _____

NEUROLOGICAL

Headaches No Yes _____

Migraines No Yes _____

Seizures / Fainting No Yes _____

ENDOCRINE

Diabetes No Yes _____

Thyroid / Other Glands No Yes _____

Intolerance to Heat or Cold No Yes _____

EARS, NOSE, MOUTH, THROAT

Hearing Loss No Yes _____

Allergies / Hay Fever No Yes _____

Chronic Cough No Yes _____

Dry Throat / Mouth No Yes _____

RESPIRATORY

Asthma / Emphysema No Yes _____

Chronic Bronchitis No Yes _____

CARDIOVASCULAR / VASCULAR

High Blood Pressure No Yes _____

Heart / Chest Pain No Yes _____

Vascular Disease No Yes _____

High Cholesterol No Yes _____

GASTROINTESTINAL

Diarrhea / Constipation No Yes _____

Abdominal Pain / Ulcers No Yes _____

Nausea / Vomiting No Yes _____

GENITOURINARY

Genitals / Kidney / Bladder No Yes _____

LYMPHATIC / HEMATOLOGIC

Anemia No Yes _____

Bleeding Problems No Yes _____

Bruising No Yes _____

ALLERGIC / IMMUNOLOGIC

No Yes _____

OPTOMAP IF THE RECEPTIONIST HAS NOT GIVEN YOU THE INFORMATION ON THE OPTOMAP RETINAL EXAMINATION, PLEASE ASK. IT IS A NEW, INNOVATIVE PROCEDURE THAT IS HIGHLY RECOMMENDED BY YOUR OPTOMETRIST. DO YOU WISH TO INCLUDE THE OPTOMAP IN YOUR EXAM? ACCEPT DECLINE

ASSIGNMENT AND RELEASE

I acknowledge that I received a copy of Eyecare Associates of Columbus, P.C. Notice of Privacy Practices. I authorize the release of any medical information necessary to process all claims. I also authorize the release of payment of medical benefits to my physician and understand I am responsible for non-covered services. For your protection, Nebraska law requires the following to appear on this form. Any person who knowingly presents false for fraudulent claims for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Our office policy is that if your account has a credit balance of under \$10.00 it will remain your account to be used as a credit for future visits.

Patients Signature _____ Date _____

SKIP THIS SECTION PLEASE . . . IN OFFICE USE ONLY

Doctors Signature _____ Date _____

Reviewed by Dr.	Date	Changes	Tech Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____