

MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Birth Date: _____

Gender: Male Female

HIPAA Notice and Acknowledgment

Acknowledgment: I acknowledge that I have received and read the Notice of Privacy Practices. Yes No

Patient Notification

A Routine Eye Examination (covered by Vision Insurance Plans) covers a prescription to address the following vision conditions: Near-Sightedness, Far-Sightedness, Astigmatism and Presbyopia. All other causes of decreased vision as well as other problems and complaints (such as those listed below), may be billed medically after discussing them with the Doctor and result in higher fees.

Chief Complaint - Eyes - Are you currently experiencing any of the following:

Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glare/Light Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No
Distorted Vision/Halos	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Side Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dryness/Dry Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mucous Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excess Tearing/Watering	<input type="checkbox"/> Yes <input type="checkbox"/> No	Redness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Pain or Soreness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sandy or Gritty Feeling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Flashes/Floaters in Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Foreign Body Sensation	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Has there been a change in your vision since your last exam? Yes No

If yes, explain: _____

Ocular Conditions - Do you currently have or have you been diagnosed with the following:

Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infection of Eye or Lid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drooping Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Styes or Chalazion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Medical History

Do you have any allergies? Eyes Other _____

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

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

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

Are you pregnant? Yes No

Are you nursing? Yes No

Do you wear glasses? Yes No If yes, how old is your present pair of lenses?: _____

Do you wear contact lenses? Yes No If yes, how old is your present pair of lenses?: _____

Type of contact lenses? Rigid Soft Extended Other Are they comfortable? Yes No

Do you over wear your contacts? Yes or No

Do you sleep in your contacts? Yes or No

If so, How long until you take them out of your eyes? _____

I have reviewed my previous Medical History Questionnaire and there are no changes.

Initial Date Initial Date Initial Date Initial Date Initial Date Initial Date

I have initial / dated next to any changes from my previous visit.

Initial Date Initial Date Initial Date Initial Date Initial Date Initial Date



