

Medical History Questionnaire

Name: _____

Today's Date: _____

Address: _____

Phone: _____

Work Phone: _____

Birth Date: _____

Cell Phone: _____

Social Security #: _____

E-Mail: _____

Employer: _____

Occupation: _____

Employer's Address: _____

Hobbies: _____

When was your last Medical Exam: _____

Last Eye Exam: _____

Who is your Medical Doctor: _____

Spouse/Guardian: _____

Spouse/Guardian Employer: _____

Spouse/Guardian Date of Birth: _____

Spouse/Guardian work phone: _____

Spouse/ Guardian Social Security #: _____

Name of Medical Insurance: _____

Whom may we contact in case of **EMERGENCY**: _____

Whom may we thank for **Referring** you: _____

Do you wear glasses: **YES** **NO**

If Yes how old is your current pair? _____

How long have you had glasses? _____

Do you wear contacts **YES** **NO**

If Yes how old is your current pair? _____

How long have you had contacts? _____

What is your wear schedule? _____

I authorize ProVision Eyecare, Inc. to act as my agent in helping me obtain payment of my insurance and/or medicare benefits. I authorize payment of these benefits directly to ProVision Eyecare, Inc., on my behalf for any services and materials furnished. I will be responsible for any unpaid balance. Cost incurred to collect any unpaid balance will be my responsibility.

Patient/Guardian Signature: _____

Review of Systems: Do you currently or have you ever...(check all that apply)

Constitutional

- fatigue None
- fever
- heat stroke
- weight loss/weight gain
- other _____

Ear, Nose & Throat

- hard of hearing None
- cough
- dry mouth
- earache
- other _____

Cardiovascular

- heart disease None
- hypertension
- stroke
- vascular disease
- other _____

Respiratory

- asthma None
- bronchitis
- emphysema
- other _____

Gastrointestinal

- Crohn's None
- colitis
- ulcer hernia
- digestive diarrhea
- other _____

Genitourinary

- urinary tract infections None
- kidney ailments
- painful urination
- STD
- other _____

Muskuloskeletal

- fibromyalgia None
- muscular dystrophy
- osteoarthritis
- joint pain
- other _____

Integumentary

- eczema None
- rosacea
- psoriasis
- other _____

Neurological

- M.S. None
- epilepsy
- headaches
- seizures numbness
- other _____

Psychiatric

- depression None
- panic disorder
- anxiety
- other _____

Endocrine

- non-insulin diabetes None
- insulin depend. diabetes
- diabetic x's how many years _____
- thyroid dysfunction
- other _____

Hematological/Lymphatic

- anemia None
- leukemia
- cholesterol
- other _____

Allergic/Immunological

- seasonal allergies (sinus)
- lupus
- rheumatoid arthritis
- other _____

Eyes

- dryness redness
- sandy gritty
- itching burning
- watering glare
- eye pain floaters
- sties soreness
- tired eyes halos
- flashes
- double vision
- light sensitive
- eye infections
- eye injuries
- crossed eye
- lazy eye
- drooping eyelid
- Retinal Disease**
- Glaucoma**
- Cataracts**

List any **MAJOR ILLNESS, INJURIES, OR SURGERIES** you have had: _____

List any **MEDICATIONS** you currently take:(We can copy a list if you have one) _____

Last Copied on: _____

Are you **ALLERGIC** to any medications: **YES NO** If yes please list: _____

Do you have a **FAMILY HISTORY** of: Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease. Other: _____

Do you drink **Alcohol**: **YES NO** If YES, type/ amount/ how long? _____

Do you **Smoke or use Tobacco Products**: **YES NO** If YES, type/ amount/ how long? _____

Do you use **Illegal Drugs**: **YES NO** If YES, type/ amount/ how long? _____

Have you ever been exposed to or infected with: Gonorrhea, Hepatitis, HIV, Syphilis: **YES NO**

Do you have any **OCCUPATIONAL EXPOSURES**: (Such as Radiation): _____

Office Use ONLY:

Dr's Signature/Tech initials/ Date: _____

Dr's Signature/Tech initials/ Date: _____

Dr's Signature/Tech initials/ Date: _____