

Medical History Questionnaire

Name: _____ Birth Date: _____ Today's Date: _____
 Parents names (if child) _____ Social Security # _____ - _____ - _____
 Address: _____ City _____ Zip Code _____
 Home# _____ Work # _____ Cell # _____
 E Mail Address: _____ Occupation : _____
 Employer: _____ How did you hear about us? _____
 Insurance Carrier for Vision: _____ Insurance Carrier for Medical Coverage: _____

Medical History

Last Eye Exam Date: _____ Previous Eye Care Doctor: _____
 Last Physical Exam Date: _____ Primary Care Physician(s): _____ PCP Ph # _____
 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):

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

Are you pregnant? No ___ Yes ___ Are you 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 / Lazy Eyes	___	___	_____
Glaucoma	___	___	_____
Macular Degeneration	___	___	_____
Retinal Detachment / Disease	___	___	_____
Arthritis	___	___	_____
Cancer	___	___	_____
Diabetes	___	___	_____
Heart Disease	___	___	_____
High Blood Pressure	___	___	_____
Kidney Disease	___	___	_____
Lupus	___	___	_____
Thyroid Disease	___	___	_____
Other _____	___	___	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the Dr 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: _____

Do you drink coffee? No ___ Yes ___ if yes, type/ amount/ how long: _____

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

Check mark any of your activities/hobbies:

___ Golf ___ Tennis ___ Bicycling ___ Auto ___ TV ___ Aerobics ___ Computer ___ Sports: _____
 ___ Sewing ___ Reading ___ Gaming ___ Hunting ___ Fishing ___ Swimming ___ Other _____

Do you wear glasses? 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 ___

Main reason(s) for visit: _____

Are you planing on getting: ___ Glasses ___ Sunwear ___ Contact Lenses ___ CRT Contact Lenses ___ Laser Correction

Review of Systems

Do you currently, or have you ever had an problems in the following areas:

SYSTEM	NO	YES		NO	YES
CONSTITUTIONAL			EARS, NOSE, MOUTH, THROAT		
Fever, Weight Loss / Gain	___	___	Allergies / Hay Fever	___	___
INTEGUMENTARY (Skin)	___	___	Sinus Congestion	___	___
NEUROLOGICAL			Runny Nose	___	___
Headaches	___	___	Post-Nasal Drip	___	___
Migraines	___	___	Chronic Cough	___	___
Seizures	___	___	Dry Throat / Mouth	___	___
EYES			RESPIRATORY		
Loss of Vision	___	___	Asthma	___	___
Blurred Vision	___	___	Chronic Bronchitis	___	___
Distorted Vision / Halos	___	___	Emphysema	___	___
Loss of Side Vision	___	___	VASCULAR / CARDIOVASCULAR		
Double Vision	___	___	Diabetes	___	___
Dryness	___	___	Heart Pain	___	___
Mucous Discharge	___	___	High Blood Pressure	___	___
Redness	___	___	Vascular Disease	___	___
Sandy or Gritty Feeling	___	___	GASTROINTESTINAL		
Itching	___	___	Constipation	___	___
Burning	___	___	GENITOURINARY		
Foreign Body Sensation	___	___	Genitals / Kidney / Bladder	___	___
Excess Tearing / Watering	___	___	BONES / JOINTS / MUSCLES		
Glare / Light Sensitivity	___	___	Joint Pain	___	___
Soreness	___	___	Neck Aches	___	___
Chronic Infection of Eye or Lid	___	___	Rheumatoid Arthritis	___	___
Styes or Chalazion	___	___	Muscle Pain	___	___
Flashes / Floaters in Vision	___	___	LYMPHATIC / HEMATOLOGIC		
Tired / Fatigued Eyes	___	___	Bleeding Problems	___	___
ENDOCRINE			Anemia	___	___
Thyroid / Other Glands	___	___	ALLERGIC / IMMUNOLOGIC PSYCHIATRIC		
			OTHER	___	___

List any of the following that you have had: crossed/out ward eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

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

CANCELLATION AND PAYMENT POLICY

If you cannot make your appointment we require 24 hours advance notice. If we are not notified there will be a charge of \$ 25.00 per person. Please note your insurance will not cover this fee.

I understand that the charges for professional services and materials are payable when rendered and that I am responsible for any costs of treatment not covered by my insurance. If my account is referred for collections, I agree to pay the cost of collections including attorney fees. If any legal claim arises, I agree to use arbitration.

If you make a payment to our office with a check and the check is returned or has bounced, there will be a \$30.00 fee.

I acknowledge that I received a copy of Dr. Paz' Notice of Privacy Practices. Please sign below to confirm you have read and understand our new policy. With this signature I authorize Dr. Paz to bill my insurance providers.

Doctor's Signature

Patient / Guardian Signature

Date