Medical History Questionnaire

Name:_____ Today's Date:_____

Address:_____ Phone:_____

City:_____ State_____ Zip_____ Work Phone:_____

Birthdate:_____ Social Security #:_____ Occupation:_____

Last Eye Exam:_____ Name of Eye Doctor:_____

Current Vision Problem (s):_____

_____

Do you wear glasses or contact lenses?_____ Type Of Contacts:_____

Do you have vision insurance? _____ Name of plan: _____

Medical History

Do you have any allergies to any medications? ___No ___Yes If yes, explain:_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

List any of the following that you have have: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infection or eye surgery:_____

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:

Disease/Condition				**Relationship to You:**
Blindness	___No	___Yes	___?	_____
Cataract	___No	___Yes	___?	_____
Crossed Eyes	___No	___Yes	___?	_____
Glaucoma	___No	___Yes	___?	_____
Macular Degeneration	___No	___Yes	___?	_____
Retinal Detatchment/Disease	___No	___Yes	___?	_____
Arthritis	___No	___Yes	___?	_____
Cancer	___No	___Yes	___?	_____
Diabetes	___No	___Yes	___?	_____
Heart Disease	___No	___Yes	___?	_____
High Blood Pressure	___No	___Yes	___?	_____
Kidney Disease	___No	___Yes	___?	_____
Lupus	___No	___Yes	___?	_____
Thyroid Disease	___No	___Yes	___?	_____

Other:_____

Social History ___Yes, I would prefer to discuss my Social History information with my doctor. (Check Box)

Do you drive? ___Yes ___No If yes, do you have visual difficulty when driving? ___Yes ___No If yes, please describe:_____

Do you use tobacco products? ___Yes ___No If yes, type/amount/how long:_____

Do you drink alcohol? ___Yes ___No If yes, type/amount/how long:_____

Do you use illegal drugs? ___Yes ___No If yes, type/amount/how long:_____

Please turn form over and complete side two

Review of Systems

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

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❒	❒	❒
INTEGUMENTARY (Skin)	❒	❒	❒
NEUROLOGICAL			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
EYES			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection of Eye or Lid	❒	❒	❒
Sties or Chalazion	❒	❒	❒
Flashes/Floaters in Vision	❒	❒	❒
Tired Eyes	❒	❒	❒
ENDOCRINE			
Thyroid/Other Glands	❒	❒	❒

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
RESPIRATORY			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
VASCULAR / CARDIOVASCULAR			
Diabetes	❒	❒	❒
Heart Pain	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
GASTROINTESTINAL			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
GENITOURINARY			
Genitals/Kidney/Bladder	❒	❒	❒
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
LYMPHATIC / HEMATOLOGIC			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
ALLERGIC / IMMUNOLOGIC	❒	❒	❒
PSYCHIATRIC	❒	❒	❒

PUPIL DILATION

This is a test which enlarges the size of the pupil to allow the doctor to have a complete view of the inside of the eyes. This test helps in diagnosing many eye diseases (retinal detachments, cataracts, etc.) that may not be visible through a non-dilated eye. There are usually no problems with driving after this test has been completed. The cost for this specialty test is $20.00. I do want the dilation ___Yes ___No

ACNOWLEDGEMENT OF PRIVACY NOTICE RECEIPT

ENCLOSED IS A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR COPPERFIELD TS WITH AN EFFECTIVE DATE OF APRIL 14, 2003. THE ENCLOSED COPY IS YOURS TO TAKE WITH YOU.

_____ _____

SIGNATURE OF INDIVIDUAL OR INDIVIDUAL'S REPRESENTATIVE DATE

_____

DRIVER'S LICENSE NUMBER OF INDIVIDUAL OR INDIVIDUAL'S REPRESENTATIVE

_____ _____

Doctor's Signature Date