

BARNETT VISION CENTER, LLP
Francis Barnett, OD • Angela Hase, OD • Kara Lunzman, OD
Medical History Questionnaire

Name: _____ Today's Date: ____/____/____
Spouse: _____ Parents' names if minor: _____
Address: _____ Phone: _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other
Birth Date: ____/____/____ Social Security #: XXX / XX / _____ Last Eye Exam: ____/____/____
Name of Medical Doctor: _____
☐ Hispanic ☐ Caucasian ☐ African American
☐ Native American ☐ Asian ☐ Pacific Islander
Whom may we thank for your referral to our office: _____ Preferred Language: English/Spanish/Other _____
Employer/Occupation: _____ Work Phone: _____
Insured Info – Name: _____ DOB _____ Cell Phone: _____
Insured's Employer _____ F/T or P/T Insured ID# _____

Medical History

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: _____

Height _____ Weight _____

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

Are you pregnant and/or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ 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

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	YES	NO	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

****Please turn this form over and complete side two****

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

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: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ None

Review of Systems

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

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

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

This serves as a consent for Dr. Barnett/Dr. Hase/Dr. Lunzman to examine and/or treat you or your minor child. If patient is a minor, this form must be signed by a parent/legal guardian. This also serves as a release for Barnett Vision Center, LLP to use your/minor child's protected privacy health information necessary for treatment, payment and/or health care operations.

Patient/Parent Signature	Date
Doctor's Signature	Date