Medical History Questionnaire

Name:_____ Today's Date:_____

Address:_____ Phone:_____

_____ Work Phone:_____

Birth Date___ /___ / ___ SS#_____ Cell Phone:_____

Last Eye Exam___ / ___ / ___ Email:_____

Dilated with last exam? ☐ Yes ☐ No Location of last exam_____

Who may we thank for referring you?_____

Insurance Holders

Name:_____ SS#:_____ Birth Date___ /___ / ___

Medical History

Name of Medical Doctor_____

Do you have any allergies to medications ☐ no ☐ yes If yes, explain_____

_____

_____

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

_____

_____

_____

List any of the following that you have had: lasik, crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infection 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: ☐ Ridged ☐ Soft ☐ Disposable Brand:_____ Power:_____

Family History

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Cataract	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart disease	☐	☐	☐	_____
High blood pressures	☐	☐	☐	_____
Other_____				_____

Please turn this form over and complete side two

Social History

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty with glare or halos ☐ No ☐ Yes

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:_____

Review of Systems

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

EYES	NO	YES	?
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing / Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye	☐	☐	☐
Styes or Chalazion	☐	☐	☐
Flashes / Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid / Other Glands	☐	☐	☐

EARS, NOSE, MOUTH, THROAT	NO	YES	?
Allergies	☐	☐	☐
Sinus Congestion	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Duration _____			
A1C _____			
High Blood Pressure	☐	☐	☐
BONE / JOINT / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
CONSTITUTIONAL			
Fever, weight Loss / Gain	☐	☐	☐
GENITOURINARY			
Kidney / Bladder	☐	☐	☐
INTEGUMENTARY (Skin)			
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐

Life-style Questions

Occupation / Work you do?_____

How many hours/day on a computer?_____

What is your hobby (sports/leisure)?_____

Do you wear protective eyewear for sports or work?_____

What are you doing to protect your eyes from ultraviolet exposure?_____

Do you have sunglasses?_____

Other information/comments:_____

NOTICE

DUE TO THE CONSTANT CHANGE IN INSURANCE, IT IS NO LONGER AN EASY JOB TO INTERPRET EACH INDIVIDUAL POLICY.

PLEASE REMEMBER THAT YOUR INSURANCE POLICY IS BETWEEN YOU AND YOUR INSURANCE COMPANY AND **NOT** BETWEEN THE INSURANCE COMPANY AND THE DOCTOR. IT IS **YOUR** RESPONSIBILITY TO KNOW **YOUR** INDIVIDUAL COVERAGE.

THERE ARE TWO TYPES OF HEALTH INSURANCE THAT WILL HELP PAY FOR YOUR EYE CARE SERVICES AND OPTICAL PRODUCTS. YOU MAY HAVE BOTH TYPES AND ST CLAIR EYE ACCEPTS MOST INSURANCE PLANS IN BOTH CATEGORIES: 1) VISION PLANS (SUCH AS VSP, EYEMED AND OTHERS) AND 2) MEDICAL INSURANCE (SUCH AS BLUE CROSS/BLUE SHIELD, MEDICARE AND OTHERS).

- IF YOU HAVE BOTH TYPES OF INSURANCE PLANS IT MAY BE NECESSARY FOR US TO BILL SOME SERVICES TO ONE PLAN AND SOME SERVICES TO THE OTHERS. WE WILL FOLLOW A PROCEDURE CALLED COORDINATION OF BENEFITS TO DO THIS PROPERLY AND TO MINIMIZE YOUR OUT-OF-POCKET EXPENSE.

- IF SOME FEES ARE NOT PAID BY YOUR INSURANCE, WE WILL BILL YOU FOR THEM, SUCH AS DEDUCTIBLES, CO-PAYS OR NON-COVERED SERVICES AS ALLOWED BY THE INSURANCE CONTRACT.

NAME (print) _____

SIGNATURE_____

DATE_____