METROPOLITAN OPTICAL

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date**: _____
First *Last*

Birth Date: _____ **Sex**: Male / Female **Marital Status**: Single / Married

Address: _____
Street *City* *State* *Zip Code*

Phone: (_____)_____ (_____)_____ (_____)_____
Home *Work* *Cell*

Occupation: _____ **Employer**: _____

Email: _____

How did you hear about Metropolitan Optical? (*Check which applies*)
Google ___ Yahoo ___ Yelp ___ Facebook ___ Twitter ___ Insurance ___
Walk by ____ A friend/family member ____ If so, who? _____

Are you planning on purchasing glasses and/or contacts? Yes / No

Will you be using vision or medical insurance today? _____ Which insurance? _____

EYE CARE NEEDS

Check any of the following you have had: □ **Reading Difficulty** □ **Blurred Distance Vision** □ **Lazy Eye** □ **Retinal Disease** □ **Cataracts** □ **Eye Injury** □ **Glaucoma**

Do you wear glasses? □Yes □No If yes, how old is your present pair of glasses? _____

How many pair of glasses do you currently use?_____ Last Eye Exam: ____ / ____
Month *Year*

Do you wear contact lenses? □Yes □No If yes, how old is your present pair of contacts? _____

Type of contact lenses: □ Rigid □ Soft □ Disposable □ Other Are they comfortable? □ Yes □ No

Have you had LASIK surgery? □ Yes □ No	Are you sensitive in bright sunlight? □ Yes □ No
Do you perform fine or close-up work? □ Yes □ No	Do you have trouble reading signs when driving at night? □ Yes □ No
Are you outdoors all or part of the time? □ Yes □ No	Are you bothered by the glare from overhead lighting? □ Yes □ No
Is safety protection a concern at work? □ Yes □ No	Are you bothered by the glare from a computer screen? □ Yes □ No

What hobbies or sports do you play? _____

Eyes	**Yes**	**No**	**Family**		**Yes**	**No**	**Family**
Loss of Vision	□	□	□	Burning	□	□	□
Blurred Vision	□	□	□	Foreign Body Sensation	□	□	□
Distorted Vision	□	□	□	Excess Tearing / Watering	□	□	□
Loss of Side Vision	□	□	□	Glare / Light Sensitivity	□	□	□
Double Vision	□	□	□	Eye Pain or Soreness	□	□	□
Dryness	□	□	□	Chronic Infection of Eye / Lid	□	□	□
Mucous Discharge	□	□	□	Sty or Chalazion	□	□	□
Redness	□	□	□	Flashes / Floaters in Vision	□	□	□
Sandy or Gritty Feeling	□	□	□	Tired Eyes / Eye Strain	□	□	□
Itching	□	□	□				

HIPPA ACKNOWLEDGEMENT: I have read and understood the HIPPA notice.

ASSIGNMENT OF BENEFITS: I request that payment of the assigned insurance be made directly to Dr. Ayalew & Associates for any services rendered. I authorize Dr. Ayalew and Associates to release my medical information to CMS and agents to assess benefits payable for related services.

Signature: _____ Date: _____

MEDICAL HISTORY: Do you currently have, or do you have a family history of any of the following conditions?

	Yes	No	Family		Yes	No	Family
Ocular History							
Glaucoma	☐	☐	☐	Retinal Detachment	☐	☐	☐
Cataracts	☐	☐	☐	Macular Degeneration	☐	☐	☐

	Yes	No	Family		Yes	No	Family
Endocrine				**Genitourinary**			
Thyroid / Other Glands	☐	☐	☐	Genitals / Kidney / Bladder	☐	☐	☐
Ears, Nose, Mouth, Throat				**Bones / Joints / Muscles**			
Allergies / Hay Fever	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Sinus Congestion / Dry Throat or Mouth	☐	☐	☐	Muscle Pain / Joint Pain	☐	☐	☐
Runny Nose / Chronic Cough	☐	☐	☐	**Allergic / Immunologic**	☐	☐	☐
Respiratory				**Cancer**	☐	☐	☐
Asthma / Bronchitis	☐	☐	☐	**Skin** (Integumentary)	☐	☐	☐
Chronic Bronchitis	☐	☐	☐	**Psychiatric**	☐	☐	☐
Emphysema	☐	☐	☐	**Neurological**			
Vascular / Cardiovascular				Seizures	☐	☐	☐
Diabetes / Heart Pain	☐	☐	☐	Headaches / Migraines	☐	☐	☐
High Blood Pressure / Vascular Disease	☐	☐	☐	If so, when and how often?	_____		
Gastrointestinal					_____		
Diarrhea / Constipation	☐	☐	☐				

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

_____

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

_____

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

_____

Are you currently pregnant or nursing? Yes / No

DO NOT WRITE BELOW THIS LINE *(Doctor's Comments):*

Name: _____ Today's Date: _____

Based on your medical history and lifestyle, I'm recommending the following options for your healthy vision:

☐ Transition Lenses	☐ Occupational Lenses	☐ Polarized Lenses	☐ Indoor Tint
☐ Impact Resistant Lenses	☐ UV Blocking Lenses	☐ Anti-Reflective Coating	☐ Glare Protection
☐ High Index Lenses	☐ Polycarbonate Lenses	☐ Hypo-Allergenic Frames	☐ Other
☐ Progressive Lenses	☐ Intermediate/Computer Lenses		

I have reviewed this history with the patient: _____

Doctor's Signature / Date