MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________________________Spouse or Parent: ____________________________

Address: __________________________City: ______________________State: _________Zip: __________

Home phone: ____________________ Mobile phone: _________________E-Mail: ____________________

Date of birth: _______________Date and location of last exam (If not here): ___________________________

Primary care physician: _________________________________Date of last medical exam: ______________

Medical insurance: ____________________________________Vision insurance: ______________________

Medical History: Allergies to any medications: ____

Current medications: ____

Major surgeries and hospitalizations: ____

Are you pregnant or nursing: YES NO : Do you wear glasses? YES NO : If Yes, how old are the lenses? ________

Do you wear contacts: YES NO : If yes, how old are the lenses? ___________ Brand of Lens _________________

Social History: (This information Is kept strictly confidential. However, you may discuss this portion directly with your doctor) ____________ yes, I prefer to discuss with my doctor.

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: ______________________

Do you or any family member have or have had the following? (Grandparents, parents, siblings)

Condition	Yes	No	(You and /or family member)
Eye Injury or Surgery			
Loss of vison			
Vision Disturbances (Spots, Flashes, Halos)			
Glaucoma			
Macular Degeneration			
Cataracts			
Diabetic Retinopathy			
Amblyopia ie Lazy Eye			
Eye Turn			
Constitutional (Fever, Weight Loss)			
Ears, Nose, Throat (Sinus, Chronic Cough, Etc,)			
Respiratory (Asthma, Emphysema, Etc.)			
Cardiovascular (Hypertension, Stroke, Heart Attack, Etc.)			
Gastrointestinal			
Genitourinary (STD, Herpes, Chlamydia, Gonorrhea)			
Muscles/Bones, Joints (Arthritis, Etc.			
Endocrine (Diabetes, Thyroid, Etc.)			
Psychiatric (Depression, Anxiety, Etc.)			
Blood/Lymph (Anemia, Cholesterol, Blood Disorder, Etc.)			
Allergic/Immunologic (Hay Fever, Lupus, Etc.)			
Skin (Rash, Eczema, Etc.)			
Neurological (Headaches, MS, Stroke, Etc.)			
Cancer			

I am responsible for payment at the time of each visit for all services provided by the Doctor and not covered by insurance. My signature serves as a 'signature on file' for claims and the release of medical information to my insurance carrier(s). ***I acknowledge viewing a copy of HIPPA practices and will receive a copy upon request.***

Signature:____***Date:***____________________