

Medical History Questionnaire

Name: _____ Today's Date: _____
 Address: _____ Phone: () _____
 _____ Work: () _____
 _____ Social Security #: _____

Birth Date: ___/___/___ Employer: _____ Occupation: _____
 Age: _____ Name of Parent or Spouse: _____ Referred by: _____

Medical History E-mail: _____

Do you have any allergies to medications? No ___ Yes ___ If yes, please explain: _____

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

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

List any of the following that you have had: crossed eye, 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 set of lenses? ___
 Do you wear contact lenses No ___ Yes ___ If yes, how old is your present set of contacts? ___
 Type of contact lenses: Rigid ___ Soft ___ Extended wear ___ Are they comfortable ___

Family History

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

<u>Disease/Condition</u>	<u>NO</u>	<u>YES</u>	<u>?</u>	<u>Relationship to you</u>
Blindness	_____	_____	_____	_____
Cataract	_____	_____	_____	_____
Crossed Eyes	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Lupus	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

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

___ Yes, I would refer to discuss my Social history information directly with my doctor.

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: _____

Do you drink alcohol? No ___ Yes ___ If yes, type/amount/how long: _____

Do you use illegal drugs? No ___ Yes ___ If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ___ Gonorrhea ___ Hepatitis ___ HIV ___ Syphilis

Review of Systems

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

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

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

Doctor's Signature

Date

Insurance Information

Insurance Company: _____

Policy #: _____ Group #: _____

Does this include Vision Care? _____

Authorization and Assignment of Insurance Benefits

I hereby authorize Axis Eye Optometric Group to furnish information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I hereby assign all payments for medical services rendered or for services to be rendered. I understand that I am financially responsible for all charges, whether or not they are covered by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature

Date