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: _____

Dou 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:

Disease/Condition	NO	YES	?	Relationship to you
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	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	____	____	____
INTEGUMENTARY (SKIN)	____	____	____
NEUROLOGICAL			
Headaches	____	____	____
Migraines	____	____	____
Seizures	____	____	____
EYES			
Loss of Vision	____	____	____
Blurred vision	____	____	____
Distorted Vision/Halos	____	____	____
Loss of Side Vision	____	____	____
Double Vision	____	____	____
Dryness	____	____	____
Mucous Discharge	____	____	____
Redness	____	____	____
Sandy or Gritty Feeling	____	____	____
Itching	____	____	____
Burning	____	____	____
Foreign Body Sensation	____	____	____
Excess Tearing/Watery	____	____	____
Glare Light Sensitivity	____	____	____
Eye Pain or Soreness	____	____	____
Chronic Infections	____	____	____
Sties or Chalazion	____	____	____
Flashes/Floaters	____	____	____
Tired Eyes	____	____	____
ENDOCRINE			
Thyroid/Other Glands	____	____	____

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	____	____	____
Sinus Congestion	____	____	____
Runny Nose	____	____	____
Post-Nasal Drip	____	____	____
Chronic Cough	____	____	____
Dry Throat/Mouth	____	____	____
RESPIRATORY			
Asthma	____	____	____
Chronic Bronchitis	____	____	____
Emphysema	____	____	____
VASCULAR/CARDIOVASCULAR			
Diabetes	____	____	____
Heart Pain	____	____	____
High Blood Pressure	____	____	____
Vascular Disease	____	____	____
GASTROINTESTINAL			
Diarrhea	____	____	____
Constipation	____	____	____
GENITOURINARY			
Genitals/Kidney/Bladder	____	____	____
BONES/JOINTS/MUSCLES	____	____	____
Rheumatoid Arthritis	____	____	____
Muscle Pain	____	____	____
Joint Pain	____	____	____
LYMPHATIC/HEMATOLOGIC			
Anemia	____	____	____
Bleeding Problems	____	____	____
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 herby 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