MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

DATE OF BIRTH: _____ **AGE:** _____ **SS#:**_____ **SEX: M / F**

ADDRESS: _____ **APT #:**_____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

HOME TELEPHONE #:_____ **WORK TELEPHONE #:**_____

LEGAL GUARDIAN (IF APPLICABLE): _____

MARITAL STATUS: **SINGLE** **MARRIED** **DIVORCED** **WIDOW**

OCCUPATION: _____

LAST EYE EXAM: _____

REASON FOR VISIT: _____

PRIMARY CARE DOCTOR: _____

SYSTEMIC MEDICATIONS: (LIST NAME & DOSAGE)

_____ _____

_____ _____

_____ _____

EYE MEDICATIONS: (LIST NAME & DOSAGE)

_____ _____

_____ _____

_____ _____

LIST ANY ALLERGIES:

_____ _____

_____ _____

_____ _____

DO YOU HAVE MEDICAL INSURANCE? _____ **YES** _____ **NO**

_____ **RELATIONSHIP TO PATIENT:** _____
NAME OF RESPONSIBLE PARTY

_____ **BIRTHDATE:** _____ _____
PRIMARY INSURANCE BUSINESS NAME AND ADDRESS

MEDICARE #: _____ **BC/BS #:** _____ **MEDICAID #**_____

GHI #: _____ **OTHER (SPECIFY) #:** _____

SECONDARY INSURANCE: _____ **#:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

NAME: _____ CHART #: _____ DATE: _____

HAS THIS PATIENT EVER BEEN DIAGNOSED WITH THE FOLLOWING?

Y	**N**	**GLAUCOMA**	**Y**	**N**	**DIABETES*: _____**
Y	**N**	**CATARACT**	**Y**	**N**	**HYPERTENSION*: _____**
Y	**N**	**MACULAR DEGENERATION**	**Y**	**N**	**HEART DISEASE*: _____**
Y	**N**	**RETINAL DETACHMENT**	**Y**	**N**	**CVA/TIA/MI*: _____**
Y	**N**	**AMBLYOPIA (LAZY EYE)**	**Y**	**N**	**ASTHMA**
Y	**N**	**DIABETIC RETINOPATHY**	**Y**	**N**	**EMPHYSEMA/COPD**
Y	**N**	**EYE INJURY**	**Y**	**N**	**CANCER*: _____**
		_____	**Y**	**N**	**KIDNEY DISEASE**
			Y	**N**	**HEPATITIS**
			Y	**N**	**HIV*: _____**
			Y	**N**	**BLOOD DISORDER*: _____**

HOW LONG - * WHERE - ^

HISTORY OF EYE SURGERIES (INCLUDING LASERS)

TYPE	**EYE**	**WHEN**	**BY WHOM**

HISTORY OF SYSTEMIC SURGERIES

TYPE	**WHERE**

FAMILY HISTORY

Y	**N**	**BLINDENESS _____**	**Y**	**N**	**STRABISMUS _____**
Y	**N**	**GLAUCOMA _____**	**Y**	**N**	**LAZY EYE _____**
Y	**N**	**RETINAL DETACHMENT**	**Y**	**N**	**CATARACT**
Y	**N**	**MACULAR DEGENERATION**	**Y**	**N**	**DIABETES**

SOCIAL HISTORY

Y	**N**	**SMOKE_____**
Y	**N**	**DRINK ALCOHOL_____**
Y	**N**	**DRUG USE _____**

DO YOU WEAR CORRECTIVE LENSES Y N

PATIENT SIGNATURE: _____ DATE: _____

MD _____ DATE: _____