Medical History Questionnaire

*** IN ORDER FOR YOUR INSURANCE COMPANY TO BE BILLED, THIS FORM MUST BE FILLED OUT COMPLETELY (FRONT & BACK)***

Patient's Name: _____ Last Eye Exam: _____/_____/_____Today's Date: _____/_____/_____

Spouse's Name: _____ Last Medical Exam: _____/_____/_____

Dependent's Name(s): _____ DOB: ____/____/_____ Age: _____ Sex: M F Race: _____

_____ Home Phone: __(_____)_____

Address: _____ Mobile Phone: __(_____)_____

_____ Occupation: _____

Patient's Social Security #: _____-_____-_____ Work Phone: __(_____)_____

Health Insurance: _____ Vision Insurance: _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Number: _____ Policy Number: _____

Policy Holder Social Security #: _____-_____-_____ DOB: ___/___/_____ Policy Holder Social Security #: ____-____-_____ DOB: ___/____/_____

Medical History

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

_____

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

_____

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

_____

Circle any of the following that you have had: Crossed Eyes, Lazy Eye, Drooping Eyelid, Prominent Eyes, Glaucoma, Retinal Disease, Cataracts, Eye Infections.

…Are you pregnant and/or nursing? No Yes

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	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____				_____

Do you…..	No	Yes
…work at a computer for long periods?	☐	☐
…wear more than one pair of glasses?	☐	☐
…want information on thinner, lighter lenses?	☐	☐
...wear Bifocals?	☐	☐
…spend time outdoors? (how much?)	☐	☐
…have prescription sunglasses?	☐	☐
…have problems with glare or reflection	☐	☐
particularly when driving at night?	☐	☐
…have you ever worn/are currently wearing	☐	☐
contacts?	☐	☐
…Are you interested in contact lenses?	☐	☐
… What time of the day do you become aware of your contacts?	_____	
…Rate your contacts overall performance and Vision from 1-10 1-Poor 10- Excellent	_____	
Would you be interested in wearing a Daily disposable contact lens occasionally instead of glasses?	☐	☐
Are you planning on getting new glasses today?	☐	☐
Are you planning on getting new contacts today?	☐	☐

** Please turn this form over and complete other side **

Social History

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

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

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 / Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes / Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐

SYSTEM	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	☐	☐	☐
ENDOCRINE			
Thyroid / Other Glands	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PHYCHIATRIC	☐	☐	☐

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

_____

_____

_____

_____

_____ _____

Doctor's Signature Date

SMS Messaging

OPT-IN CONSENT FORM

"By submitting this form, I consent to receive SMS text messages from Arkansas Family Eyecare of Searcy for appointment reminders, marketing messages, and general two-way communication. Msg frequency varies. Msg&data rates may apply. Reply HELP for support. Reply STOP to opt out."

Phone number _____

Signature _____