# MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Date:_____

Occupation:_____ Address:_____

Social Security #:_____ _____

Email_____ Phone: Home_____ Cell_____
Work_____

**Chief Complaint:_____**
**A medical complaint includes blurry vision, watery, itchy eyes, flashes, floaters, vision loss, pain, light sensitivity, pressure, etc.**
**If you do not have a medical complaint and are here for a routine check-up, then MEDICARE will not cover this exam.**

Date of **Birth**_____**Male**___ **Female**____ Date of **last eye exam**_____
List of any medications you currently take (RX and over-the-counter)_____
_____

Do you have **allergies** to any medications? **YES** **NO**
If YES, list the medications:_____

List all **major illness** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):_____

List any **surgeries** you have had (cataract, appendectomy):_____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| **EYES** (poor vision, eye pain, tearing, redness etc) | | | **FEMALES** Are you pregnant? Nursing? | | |
| **PSYCHIATRIC** (anxiety, depression, insomnia) | | | **CARDIOVASCULAR** (high BP, racing pulse, etc.) | | |
| **ENDORINE** (diabetes, hypothyroid, etc.) | | | **SKIN** (pimples, warts, growths, rash, etc.) | | |
| **MUSCLES, BONES, JOINTS** (joint pain, stiffness, swelling, cramps, artritis, etc.) | | | **BLOOD/LYMPH** (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.) | | |
| **GASTROINTESTINAL** (stomach upset, diarrhea, constipation, hernia, ulcers, etc.) | | | **ALLERIGIC/IMMUNOLOGIC** (sneezing, swelling, redness, itching, hives, lupus, etc.) | | |
| **RESPIRATIORY** (congestions, wheezing, short of breath, etc) | | | **GENITAL, KIDNEY, BLADDER** (painful urination, frequent urination, impotence, yellow jaundice, etc.) | | |
| **NEUROLOGICAL** (numbness, headache, seizures, paralysis, etc.) | | | **EARS, NOSE, THROAT** (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.) | | |

**FAMILY HISTORY**

Has any member of your family had these diseases? (circle all that apply) **YES** **NO** **UNKNOWN**

**Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis**
Other heritable disease:_____

**SOCIAL HISTORY**

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES** **NO**
Have you ever had a blood transfusion?.....**YES** **NO**
Do you drink alcohol?……..**YES** **NO** If YES, how much?_____
Do you smoke?.....**YES** **NO** If YES, how much?_____ How many years?_____

The Florida Board of Optometry has established that a comprehensive eye examination for a new patient includes a Dilated Fundus Exam. This procedure involves putting one or more drops in each eye that will dilate the pupils. The doctor will then study the internal structures of the eye to ensure proper health.

The drops will cause the eyes to be light sensitive and vision will be blurred, especially with near work, for 4-6 hours. In some people the effects will be longer. Driving may be difficult and should be done with extreme caution.

I have read the above statement and:
_____I agree to have my eyes dilated today.
_____I do not agree to have my eyes dilated.

## HIPPA PRIVACY (Acknowledgement of Receipt of Privacy Notice)

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with my regarding vision care services provided by the Location (for example, mailings of exam reminders or information about services / products provided by the Location).

**I can be assured that this Location does not sell my personal health of any kind to a third party for such party's own use.** I authorize the Location to submit my vision benefit claim to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from the Location.

Patient Signature or Patient's Legal Representative_____Date:_____

Physician's Signature:_____Date:_____