MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME	SOC. SEC. #	DRIVER'S LICENSE #	TODAY'S DATE

ADDRESS	CITY	STATE	ZIP

HOME PHONE	BUSINESS PHONE	EMAIL ADDRESS

OCCUPATION	EMPLOYER

NAME OF PARENT OR SPOUSE	GRADE IF STUDENT	BIRTHDATE

ARE YOU INTERESTED IN LASIK VISION CORRECTION?

HAVE WE SEEN OTHER MEMBERS OF YOUR FAMILY? ❑ YES ❑ NO
IF YES, WHOM?

ACCOUNT RESPONSIBLE

Name _____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ other

Address *(if different than above)* _____ City, State, Zip _____

Date of Birth _____ Social Security # _____ Driver's License # _____

Pesponsible Party Phone # _____ Employer _____

This document is to serve as my signature on file. I authorize payment of insurance benefits to FIRST EYE CARE. All professional fees must be paid at time of service. If insurance coverage is denied or if I am ineligible for benefits at the time of service, I understand that I will be held responsible and liable for all services and materials. ***Any charges that are not covered by my insurance company will need to be paid.***

Signed:

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: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injury or eye surgery?: _____

Are you interested in being fit in contact lenses? ❑ no ❑ yes
Are you pregnant and/or nursing? ❑ no ❑ yes
Do you wear glasses? ❑ no ❑ yes If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? ❑ no ❑ yes If yes, how old is your present pair of lenses? _____
Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ yes ❑ no

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	❑	❑	❑	
Kidnev Disease	❑	❑	❑	
Lupus	❑	❑	❑	
Thyroid Disease	❑	❑	❑	
Other _____	❑	❑	❑	

Please turn this form over and complete side two

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	❑	❑	❑
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 & list medications:

_____

_____

_____

_____

_____

_____

_____

Doctor's Signature _____ Date _____