MODERN EYEWEAR
OPTOMETRY

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# Medical History Questionnaire

## Patient History and Information

Name: _____
Last First Middle Initial Nickname

Address: _____
Street name City State Zip

Date of Birth: _____ Age: _____ SSN (required for insurance): _____ Sex: Male / Female

Phone Number: _____
(circle preferred) Home Cell Work

E-mail: _____ Marital Status: Single / Married / Other

Date of Last Eye Exam: _____ Occupation: _____ Employer: _____

Date of Last Medical Exam: _____ Physician: _____ Phone Number: _____

How were you referred to our office?: _____

## Insurance Information

***Vision Insurance Carrier:***

VSP / EyeMed / MES / Unknown / None / Other: _____ Policy Number: _____

If you are not the policy holder:

Policy holder's name: _____ Self / Spouse / Parent / Other: _____

Primary Member's SSN: _____ Primary Member's Date of Birth: _____

***Medical Insurance Carrier (for emergency / medical eye appointments as needed):***

Medicare / Blue Cross / Blue Shield / Aetna / Cigna / HealthNet / Other: _____

Policy Number: _____ Is your insurance PPO / HMO / Other: _____

If you are not the policy holder:

Policy holder's name: _____ Self / Spouse / Parent / Other: _____

Primary Member's SSN: _____ Primary Member's Date of Birth: _____

## Eye Conditions

Have you ever been diagnosed with any of the following:

| | | |
|---|---|---|
| Cataract | Yes | No |
| Age-Related Macular Degeneration | Yes | No |
| Glaucoma | Yes | No |
| Diabetes | Yes | No |
| Diabetic Retinopathy | Yes | No |
| Dry Eye | Yes | No |
| Eye infection, inflammation, or allergy | Yes | No |
| Floaters | Yes | No |
| Flashes of light | Yes | No |
| Other: _____ | Yes | No |

## Eye / Vision Concerns

Do you have any of the following concerns:

| | | |
|---|---|---|
| Redness | Yes | No |
| Burning | Yes | No |
| Itching | Yes | No |
| Tearing | Yes | No |
| Discharge | Yes | No |
| Blurred Vision | Yes | No |
| Eyestrain | Yes | No |
| Eye Pain | Yes | No |
| Sensitivity to lights | Yes | No |
| Poor night vision | Yes | No |
| Double vision | Yes | No |
| Other: _____ | Yes | No |

## Current Vision Needs / Desires

| | | | |
|---|---|---|---|
| Do you currently wear glasses? | Yes | No | |
| Do you use the computer? | Yes | No | If so, how many hours per day? _____ |
| Do you wear contact lenses? | Yes | No | Soft / Hard / Hybrid / RGP / bifocal / corneal molding |
| If not, are you interested in contact lenses? | Yes | No | |
| Do you play any sports? | Yes | No | If so, which ones? _____ |
| Do you have any special hobbies? | Yes | No | If so, what are they? _____ |
| Are you interested in LASIK? | Yes | No | |

## Review of Systems

Do you currently, or have your ever had any problems in the following areas:

| | | |
|---|---|---|
| *Constitutional* | | |
| Fever, Weight / Loss / Gain | Yes | No |
| *Integumentary (Skin)* | Yes | No |
| *Endocrine* | | |
| Thyroid | Yes | No |
| *Neurological* | | |
| Headaches | Yes | No |
| Migraines | Yes | No |
| Seizures | Yes | No |
| *Vascular / Cardiovascular* | | |
| Diabetes | Yes | No |
| High blood pressure | Yes | No |
| Vascular Disease | Yes | No |
| *Lymphatic / Hematologic* | | |
| Rheumatoid Arthritis | Yes | No |

| | | |
|---|---|---|
| *Ears, Nose, and Throat* | | |
| Allergy / Hay Fever | Yes | No |
| Nasal congestion | Yes | No |
| Sinisitis | Yes | No |
| Post-Nasal Drip | Yes | No |
| Chronic Cough | Yes | No |
| Dry Throat / Mouth | Yes | No |
| *Respiratory* | | |
| Asthma | Yes | No |
| Chronic Bronchitis | Yes | No |
| Emphysema | Yes | No |
| *Gastrointestinal* | | |
| Diarrhea | Yes | No |
| Constipation | Yes | No |
| *Psychiatric* | | |
| Depression or Anxiety | Yes | No |

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

_____

_____

## Medications

Please list any medications you are currently taking: _____
_____
_____
_____

Please list any allergies (to medications or other) that you have: _____
_____

## Surgical History

Past illnesses or injuries: _____
_____
_____

Past surgeries (including eye surgery): _____
_____
_____

## Social History

| | | | |
|---|---|---|---|
| Do you drink alcohol? | Yes | No | If yes, type / amount / how long: _____ |
| Do you smoke cigarettes? | Yes | No | If yes, type / amount / how long: _____ |
| Do you use illegal drugs? | Yes | No | If yes, type / amount / how long: _____ |

## Family History

Please note any family history (parents, grandparents, siblings, children) for the following conditions:

| | | | Relationship to you |
|---|---|---|---|
| Thyroid disease | Yes | No | _____ |
| Diabetes | Yes | No | _____ |
| Cancer | Yes | No | _____ |
| Hypertension | Yes | No | _____ |
| Kidney disease | Yes | No | _____ |
| Lupus | Yes | No | _____ |
| Heart disease | Yes | No | _____ |
| Blindness | Yes | No | _____ |
| Amblyopia or crossed eye (lazy eye) | Yes | No | _____ |
| Cataract | Yes | No | _____ |
| Age-Related Macular Degeneration | Yes | No | _____ |
| Glaucoma | Yes | No | _____ |
| Diabetic Retinopathy | Yes | No | _____ |
| Other: _____ | Yes | No | _____ |

If there is anything else about you that your general health, ocular health, or vision needs that you feel we should know, please list here: _____
_____
_____
_____
_____
_____
_____

_____ _____
Doctor's Signature Date