Medical History Questionnaire

Name: _____ Today's Date: ____/____/____
Last First Middle Initial

Preferred Name: _____

Address: _____ Home# _____

_____ Cell# _____

Birth Date: ____/____/____ Age: ____ Social Security #: _____/_____/_____ Work # _____

Occupation: _____ Place of Employment _____ Marital Status: ☐ S ☐ M ☐ W

Name of Medical Doctor _____ Spouses Name _____

Name of Emergency Contact: _____ Phone: _____ Last Eye Exam: ____/____/____

Email: _____ Last Medical Exam: ____/____/____

How did you hear about our practice? ☐ Google/Internet Search ☐ Yellow Pages ☐ Newspaper Ad

☐ Radio Ad ☐ Friend/Family Member _____ ☐ Other _____

Medical History

Do you have any allergies to medications? ☐ no ☐ yes If yes, please explain (including the reaction that occurs): _____

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

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, injury, surgeries: _____

Cataract Surgery ☐ no ☐ yes Date of Surgery: Right ____/____/____ Left ____/____/____

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 ☐ Disposables ☐ Daily Wear ☐ Extended Wear ☐ Frequent Replacement

Please turn this form over and complete side two

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	☐	☐	_____
High Blood Pressure	☐	☐	_____
Other	☐	☐	_____

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)

Any history of tobacco products? ☐ no ☐ yes If yes, type/amount/how long: _____

Any history of alcohol? ☐ no ☐ yes If yes, type/amount/how long: _____

Any history of illegal drugs? ☐ no ☐ yes If yes, type/amount/how long: _____

Acknowledgement of Consent to Treat Privacy Practices

⇨ I have been presented with a copy of the Notice of Privacy Practices for the office of Mountain Eye Clinic, P.C., detailing how my information may be used and disclosed as permitted under federal state and law and how I may obtain access to and control this information.

_____ _____

Printed Name of Patient Date

_____ _____

Signature of Patient/Parent/Guardian Relationship