

HEALTH QUESTIONNAIRE

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PATIENT NAME: _____ DATE: _____

PRIMARY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

PATIENT DATE OF BIRTH: _____ SEX: M or F MARITAL STATUS: _____

PATIENT EMPLOYER: _____ EMPLOYER PHONE NUMBER: _____

PATIENT SOCIAL SECURITY NUMBER: _____ EMERGENCY CONTACT: _____

EMERGENCY CONTACT PHONE NUMBER: _____ RELATIONSHIP: _____

HOW DID YOU HEAR ABOUT US?

INTERNET SEARCH _____ OUR WEBSITE _____ RADIO _____ NEWSPAPER _____

INSURANCE COMPANY _____ OTHER _____ REFERRED BY M.D. (Dr. Name) _____

REFERRED BY OPHTHALMOLOGIST (Dr. Name) _____

REFERRED BY FRIEND/FAMILY _____

DO YOU WEAR GLASSES? _____ HOW OLD ARE THEY? _____

DO YOU WEAR CONTACT LENSES? _____ ARE THEY SOFT DISPOSABLE / RGP / OTHER? _____

HOW OLD ARE THEY? _____ WHAT BRAND ARE THEY? _____

DO YOU WANT TO BE FIT WITH CONTACT LENSES TODAY? _____

ARE YOU HAVING PROBLEMS WITH YOUR VISION, YOUR GLASSES OR YOUR CONTACT LENSES? PLEASE EXPLAIN:

HAVE YOU HAD YOUR EYES DILATED BEFORE? _____

MEDICAL HISTORY DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- | | | | | | |
|-----------------------|------------------------------|--------------------|----------|--------------------------|----------|
| 1. PREGNANT / NURSING | YES / NO | 10. EYE INFECTIONS | YES / NO | 18. RETINAL DETACHMENT | YES / NO |
| 2. INJURIES | YES / NO | 11. PROMINENT EYES | YES / NO | 19. RETINAL DISEASE | YES / NO |
| 3. ALLERGIES | YES / NO | 12. GLAUCOMA | YES / NO | 20. STROKE | YES / NO |
| 4. SURGERIES | YES / NO | 13. EYE INJURIES | YES / NO | 21. HEART DISEASE | YES / NO |
| 5. CATARACTS / SX | YES / NO | 14. HEADACHES | YES / NO | 22. HIGH BLOOD PRESSURE | YES / NO |
| 6. LAZY EYE | YES / NO | 15. MIGRAINES | YES / NO | 23. SEE SPOTS OR FLASHES | YES / NO |
| 7. DROOPY LIDS | YES / NO | 16. LASIK SURGERY | YES / NO | 24. THYROID PROBLEM | YES / NO |
| 8. CROSSED EYES | YES / NO | 17. DOUBLE VISION | YES / NO | 25. HEART ATTACK | YES / NO |
| 9. DIABETES | YES / NO ** TYPE I / TYPE II | 26. MEDICATIONS | | YES / NO | |

IF YOU CIRCLED YES TO ANY OF THE ABOVE EXPLAIN AND LIST ANY MEDICATIONS: _____

FAMILY HISTORY HAS ANY MEMBER OF YOUR FAMILY BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

- | | | | | | |
|-----------------|----------|------------------------|----------|--------------------------|----------|
| 1. BLINDNESS | YES / NO | 7. HEART DISEASE | YES / NO | 13. RETINAL DISEASE | YES / NO |
| 2. CATARACT | YES / NO | 8. HIGH BLOOD PRESSURE | YES / NO | 14. RETINAL DETACHMENT | YES / NO |
| 3. CROSSED EYES | YES / NO | 9. KIDNEY DISEASE | YES / NO | 15. MACULAR DEGENERATION | YES / NO |
| 4. GLAUCOMA | YES / NO | 10. THYROID DISEASE | YES / NO | 16. OTHER | _____ |
| 5. DIABETES | YES / NO | 11. ARTHRITIS | YES / NO | | |
| 6. LUPUS | YES / NO | 12. CANCER | YES / NO | | |

PLEASE EXPLAIN: _____

SOCIAL HISTORY

DO YOU DRIVE? YES / NO DO YOU HAVE VISUAL DIFFICULTY WHILE DRIVING? _____
DO YOU USE TABACCO PRODUCTS? YES / NO DO YOU DRINK ALCOHOL? YES / NO DO YOU USE ILLEGAL DRUGS? YES / NO
HAVE YOU EVER BEEN EXPOSED TO OR INFECTED WITH: HEPATITIS or HIV? _____

REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas:

SYSTEM

CONSTITUTIONAL

FEVER, WEIGHT LOSS/GAIN Y / N

INTEGUMENTARY (SKIN) Y / N

NEUROLOGICAL

HEADACHES Y / N

MIGRAINES Y / N

SEIZURES Y / N

EYES

LOSS OF VISION Y / N

BLURRED VISION Y / N

DISTORTED VISION/HALOS Y / N

LOSS OF SIDE VISION Y / N

DOUBLE VISION Y / N

DRYNESS Y / N

MUCOUS DISCHARGE Y / N

REDNESS Y / N

SANDY OR GITTY FEELING Y / N

ITCHING Y / N

BURNING Y / N

FOREIGN BODY SENSATION Y / N

EXCESS TEARING/WATERING Y / N

GLARE/LIGHT SENSITIVITY Y / N

EYE PAIN OR SORENESS Y / N

CHRONIC INFECTION EYE/LID Y / N

STIES OR CHALAZION Y / N

FLASHES / FLOATERS IN VISION Y / N

TIRED EYES Y / N

ENDOCRINE

THYROID/OTHER GLANDS Y / N

EARS, NOSE, MOUTH, THROAT

ALLERGIES/HAY FEVER Y / N

SINUS CONGESTION Y / N

RUNNY NOSE Y / N

POST-NASAL DRIP Y / N

CHRONIC COUGH Y / N

DRY THROAT/MOUTH Y / N

RESPIRATORY

ASTHMA Y / N

CHRONIC BRONCHITIS Y / N

EMPHYSEMA Y / N

VASCULAR/CARDIOVASCULAR

DIABETES Y / N

HEART PAIN Y / N

HIGH BLOOD PRESSURE Y / N

VASCULAR DISEASE Y / N

GASTROINTESTINAL

DIARRHEA Y / N

CONSTIPATION Y / N

GENITOURINARY

GENITALS/KIDNEY/BLADDER Y / N

BONES/JOINTS/MUSCLES

RHEUMATOID ARTHRITIS Y / N

MUSCLE PAIN Y / N

JOINT PAIN Y / N

LYMPHATIC/HEMATOLOGIC

ANEMIA Y / N

BLEEDING PROBLEMS Y / N

ALLERGIC/IMMUNOLOGIC Y / N

PSYCHIATRIC Y / N

IF YOU ANSWERED YES TO ANY OF THE ABOVE OR HAVE A CONDITION NOT LISTED, PLEASE EXPLAIN & LIST MEDICATIONS: _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS OR OTHER INSURANCE BE MADE EITHER TO ME OR ON MY BEHALF TO DR. SMITH OR ANY SERVICES FURNISHED ME BY THAT DOCTOR. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

LIFETIME PATIENT SIGNATURE _____ DATE _____

DOCTOR SIGNATURE _____ DATE _____

REVIEWED PREVIOUS HISTORY (PERSONAL/FAMILY) AND TOTAL CASE RECORD. ANY CHANGES NOTED AND RECORDED IN ABOVE DATED VISIT. THIS VISIT PART OF TOTAL CASE RECORD.