Medical History Questionnaire

Name: _____ Today's Date: ____ / ____ / ____

Address: _____ Phone: _____

City: _____ Zip: _____ Work Phone: _____

Guardian (If Applicable): _____ Occupation: _____

Birth Date: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Last Eye Exam: ____ / ____ / ____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Last Medical Exam: ____ / ____ / ____

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 hospitalization 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 or eye injury: _____

Are you pregnant and /or nursing? ☐ ☐

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	DISEASE / CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness	☐	☐	_____	Cancer	☐	☐	_____
Cataracts	☐	☐	_____	Diabetes	☐	☐	_____
Crossed eyes	☐	☐	_____	Heart disease	☐	☐	_____
Glaucoma	☐	☐	_____	High Blood Pressure	☐	☐	_____
Macular Degeneration	☐	☐	_____	Kidney Disease	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____	Lupus	☐	☐	_____
Arthritis	☐	☐	_____	Thyroid Disease	☐	☐	_____
				Other _____	☐	☐	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with you 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

✳ Please turn this form over and complete side two ✳

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:

_____

_____

_____

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to **Robert D. Hillstead, O.D., Inc.** for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If i have other health insurance coverage (as indicated in item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

The Patient understands that:

- I assume full responsibility for all charges incurred.
- Protected health information may be disclosed or used for treatment, payment or health care operations
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restict the use of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Lifetime Patient Signature: _____ **Date:** ____/____/____

Doctors Signature: _____ **Date:** ____/____/____