Medical History Questionnaire

Patient's Name: _____ Birth Date: _____ Today's Date: _____

Medical History

Last Physical: _____ Last Eye Exam: _____

Allergies to medications: None ☐ Yes ☐ ; if yes, name of medication(s):_____

List Medications you take (including oral contraceptives, aspirin, and over the counter meds and home remedies):

_____

_____

List all major injuries, and surgeries you have had: _____

Are you pregnant and/or breast feeding: No ☐ Yes ☐

Eye surgeries or eye injuries you have had:_____

List any eye disease you have (such as Glaucoma, Cataracts, Retinal disease, crossed eyes, lazy eye):_____

Do you wear Glasses? No ☐ Yes ☐ How old are they? _____ Any problems? _____

Do you wear Contact Lenses? No ☐ Yes ☐ How old is present set? _____ Problems? _____

What type of Contact Lenses? Disposable Daily Wear Soft ☐ Disposable Extended Wear Soft ☐ Gas Permeable/Rigid ☐

Do you remember the name and prescription of your Contact Lenses? No ☐ Yes ☐ _____

FAMILY HISTORY
(Parents, grandparents, brothers, sisters, children; living or deceased)

	NO	YES	RELATIONSHIP TO YOU (Mother/Father/Grandmother/Grandfather/etc)
Blindness	☐	☐	_____
Cataracts	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Arthritis	☐	☐	_____
Cancer (and type)	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Thyroid Disease	☐	☐	_____
Other	☐	☐	_____

**** Please Continue on the back of this page****

Social History *This information is confidential. However, you may discuss directly with the doctor if you prefer*

Any Sports or Hobbies: _____ COMPUTER USAGE (hours per day): _____

Do you Drive? No ☐ Yes ☐ If you drive, any problems? No ☐ Yes ☐ check off; night glare ☐ day time glare ☐

Any other visual difficulty while driving? Explain_____

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: Hepatitis ☐ HIV ☐ Gonorrhea ☐ Syphilis ☐ None ☐

Review of Systems Do you presently have or had problems in the following areas?

System	NO	YES
CONSTITUTIONAL		
Fever, Weight Gain/Loss	☐	☐
INTEGUMENTARY (Skin)	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dry Eyes/Burning Sensation	☐	☐
Sandy or Gritty Eyes	☐	☐
Redness	☐	☐
Foreign Body Sensation	☐	☐
Mucous Discharge	☐	☐
Excessive Tearing	☐	☐
Glare/Light Sensitivity	☐	☐
Eye pain	☐	☐
Chronic infection of Eye or Lids	☐	☐
Sties or Chalazion	☐	☐
Flashes of Light/Floaters in Vision	☐	☐
Itchy Eyes	☐	☐
ENDOCRINE		
Thyroid problem	☐	☐
Cholesterol/Lipid problem	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐

	NO	YES
VASCULAR/CARDIOVASCULAR		
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Vascular Disease	☐	☐
Diabetes	☐	☐
If diabetic, most recent **A1C** =_____when_____		
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	☐	☐
Sinus problems	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Mouth/Throat	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals/Kidney/Bladder	☐	☐
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATIC/HEMATOLOGIC		
Anemia	☐	☐
Bleeding problems	☐	☐
IMMUNOLOGIC/ALLERGIC	☐	☐
Type_____		
PSYCHIATRIC (circle)		
Anxiety/Depression/ADD/ADHD		
Dementia/Schizophrenia/Alzheimer's		
Other_____		

If you answered YES to any condition above, please explain:

_____

_____

_____

PLEASE TURN OFF CELL PHONE IN EXAM AREA

Patient Registration
Dr. Carlos E. Green
Optometry

Cellphone #_____ **E-mail:**_____

Name_____ **Birthdate**_____

Home Address_____
Street **City** **Zip Code**

Home Phone_____ **Social Security # XXX-XX-**_____

Occupation_____ **Employer**_____ **Phone:**_____

Primary Care Physician:_____ **Phone:**_____

VISION INSURANCE: **VSP**___ **MESC**___ **ARTA**___ **SAFEGUARD**___ **EYEMED**___
BLUE SHIELD PPO___ **CAL OPTIMA**___ **MEDICARE**___ **OTHER**_____
MEDICAL INSURANCE: **HMO:**___ **PPO:**_____

ALL FEES ARE DUE AND PAYABLE ON THE SAME DAY OF SERVICE

Notice of Privacy Practice

During the course of providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to evaluate or treat you, obtain payment for our services, and to conduct health care operations involving our office. The *Notice of Privacy Practices* is posted in our reception area. If you would like a copy for your own records, please let us know.

I acknowledge that I have been notified that I have rights of privacy, and the Notice of Privacy Practices are posted in the reception area of Dr. Green's office or I may request a copy.

Signature_____ **Date**_____

Adult & Pediatric Eye Care/Ocular Disease Detection, Treatment, Management/Refractive Surgery Consultant/
Specialty Contact Lenses/Glasses
Spanish Bilingual

6/2014

Patient Registration
Dr. Carlos E. Green
Optometry

Parent/Guardian Cellphone #_____ **E-mail:**_____

Minor's Name_____ **Birthdate**_____

Home Address_____
Street City Zip Code

Home Phone_____ **Seguro Social # XXX-XX-**_____

Pediatrician's Name:_____ **Phone:**_____

Name of Parent/Guardian Responsible _____

Parent/Guardian Address Same as Minor Yes

If not, Address_____

Home Phone_____ **Social Security # XXX-XX-**_____

ALL FEES ARE DUE AND PAYABLE ON THE SAME DAY OF SERVICE

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