Medical History Questionnaire

Gender: M F Full Legal Name_____ Date_____
Last, First, Middle Initial mo/day/yr
Nickname_____ Marital Status:_____ Email address: _____
Address_____
City State Zip
Best ph. # to reach you at: _____Home/Cell/Work (circle one) Alternate: _____
Social Security #_____Birth Date_____ Age _____ Responsible Party_____
Name of Parents/guardian (if under 18) _____
Emergency Contact _____Relationship_____Phone_____
How did you hear about us? _____

Insurance Information ***Please present all Insurance & ID cards at front desk to have scanned into records.***
Do you have vision and/or medical insurance? Y N
Vision Insurance (Circle One): EyeMed VSP Superior PCHP Other: _____
Primary Medical Insurance (circle one): Medicare, Medicaid, Anthem, Aetna, Blue Cross Blue Shield, Cigna, Humana, PCHP, United HealthCare, Virginia Premier Other: _____
Who is your Secondary Insurance? _____

Ocular History:	***Yes***	***No (check all boxes even if no)***	
EYE (permanent 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, infection of eye lid, styes or chalazion, floaters in vision, light flashes			Explain any symptoms and include any past eye surgeries and/or injuries:
Blindness			
Cataract			
Crossed Eyes			
Drooping eyelid			
Lazy eye			
Glaucoma			
Macular Degeneration			
Retinal Detachment/disease			
Other			

List any ***ocular*** medications you take: (eye medications or OTC drops)
_____

Family Ocular History (specify relationship): Glaucoma _____Cataracts_____ Crossed/Lazy Eye_____ Macular Degeneration_____ Retinal Detachment_____
Other: _____

If a contact lens wearer, what type have you worn in the past? _____ how often do you replace your lenses? _____ How many nights do you sleep in them on average per week? _____

Race (circle)	***Ethnicity (circle)***	***Preferred Language (circle)***
American Indian or Alaska Native	Hispanic or Latino	English
Asian	Not Hispanic or Latino	Spanish
Black or African American	Other :	Other :
Native Hawaiian or other Pacific Islander	I decline to specify	
White		
Other :		
I decline to specify		

Review of systems: (check all boxes even if no)	***Yes***	***No***	***Specify or Explain the Problem***
GENERAL (fever, weight loss, cancer, other)			
EARS, NOSE, THROAT (sinus, ear infection, chronic cough, dry mouth, etc)			
CARDIOVASCULAR (high blood pressure, heart pain, vascular disease, etc)			
RESPIRATORY (asthma, chronic bronchitis, emphysema, etc)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (rheumatoid arthritis, muscle pain, joint pain)			
SKIN (eczema, skin cancer, acne, etc.)			
NEUROLOGICAL (headaches, migraines, seizures, multiple sclerosis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc)			
ENDOCRINE (diabetes, hypothyroid, etc.			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (hay fever, lupus, sjogrens, etc			
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc.)			
Any other conditions you have been diagnosed with or are being treated for?			

Check all that apply: Pregnant _____ Nursing _____
Who is your family medical doctor? _____

List any medications you take (list name, strength, and dosage, including vitamins, OTC products and oral contraceptives):

_____

_____

_____

Do you have any allergies to medications? Yes___ No ____ Explain: _____

Any Injuries, Surgeries, Hospitalizations_____

Family Medical History	***Yes***	***No***	***Relationship to Patient***
Blindness or Glaucoma			
Rheumatoid Arthritis			
Cancer			
Kidney Disease			
Heart disease or high blood pressure			
Diabetes, thyroid disease, stroke, lupus			
Other			

Occupation_____ Employer _____

Do you drink alcohol? Y N beer, wine, hard liquor

Do you use illegal drugs? Y N
Do you currently have or have you ever been exposed to: gonorrhea, syphilis, hepatitis, HIV, TB

Smoking Status (circle all that apply): Never smoker, current everyday smoker, former smoker, occasional day smoker, light smoker (<10 cigs/day), heavy smoker (>10 cigs/day),

I certify that this is true to the best of my knowledge.

Patient Signature_____

Print Name _____ Date: _____

FOR OFFICE USE ONLY
EMR Complete □ Initial _____ Date_____