Medical History Questionnaire

Name: ______________________________ Birth Date: ______________

Gender: ☐ Male ☐ Female

HIPAA Notice and Acknowledgment

Acknowledgment: I acknowledge that I have received and read the Notice of Privacy Practices. ❑ Yes ❑ No

Patient Notification

A Routine Eye Examination (covered by Vision Insurance Plans) covers a prescription to address the following vision conditions: Near-Sightedness, Far-Sightedness, Astigmatism and Presbyopia. All other causes of decreased vision as well as other problems and complaints (such as those listed below), may be billed medically after discussing them with the Doctor and result in higher fees.

Chief Complaint - Eyes - Are you currently experiencing any of the following:

Blurred Vision	❑ Yes	❑ No	Glare/Light Sensitivity	❑ Yes	❑ No
Burning	❑ Yes	❑ No	Itching	❑ Yes	❑ No
Distorted Vision/Halos	❑ Yes	❑ No	Loss of Side Vision	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No	Loss of Vision	❑ Yes	❑ No
Dryness/Dry Eyes	❑ Yes	❑ No	Mucous Discharge	❑ Yes	❑ No
Excess Tearing/Watering	❑ Yes	❑ No	Redness	❑ Yes	❑ No
Eye Pain or Soreness	❑ Yes	❑ No	Sandy or Gritty Feeling	❑ Yes	❑ No
Flashes/Floaters in Vision	❑ Yes	❑ No	Tired Eyes	❑ Yes	❑ No
Foreign Body Sensation	❑ Yes	❑ No			

Has there been a change in your vision since your last exam? ❑ Yes ❑ No

If yes, explain: ______________________________

Ocular Conditions - Do you currently have or have you been diagnosed with the following:

Cataracts	❑ Yes	❑ No	Infection of Eye or Lid	❑ Yes	❑ No
Crossed Eyes	❑ Yes	❑ No	Lazy Eye	❑ Yes	❑ No
Drooping Eyelid	❑ Yes	❑ No	Retinal Disease	❑ Yes	❑ No
Eye Injury	❑ Yes	❑ No	Styes or Chalazion	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No			

Medical History

Do you have any allergies? ❑ Eyes ❑ Other ______________________________

Do you have any allergies to medications? ❑ Yes ❑ No If yes, explain: ______________________________

____

List any medications you take (including oral contraceptives, aspirin, over the counter medications, and herbal supplements): ______________

____

List all major injuries, surgeries and/or hospitalizations you have had: ______________________________

____

Are you pregnant? ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Do you wear glasses? ❑ Yes ❑ No If yes, how old is your present pair of lenses?: ______________

Do you wear contact lenses? ❑ Yes ❑ No If yes, how old is your present pair of lenses?: ______________

Type of contact lenses? ❑ Rigid ❑ Soft ❑ Extended ❑ Other Are they comfortable? ❑ Yes ❑ No

Do you over wear your contacts? ❑ Yes or ❑ No

Do you sleep in your contacts? ❑ Yes or ❑ No

If so, How long until you take them out of your eyes? ______________________________

I have reviewed my previous Medical History Questionnaire and there are no changes.

Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date

I have initial / dated next to any changes from my previous visit.

Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date

Family History

Disease / Condition	Yes	No	?	Relationship to You
Blindness	❑ Yes	❑ No	❑ ?	______
Cataract	❑ Yes	❑ No	❑ ?	______
Crossed Eyes	❑ Yes	❑ No	❑ ?	______
Glaucoma	❑ Yes	❑ No	❑ ?	______
Macular Degeneration	❑ Yes	❑ No	❑ ?	______
Retinal Detachment / Disease	❑ Yes	❑ No	❑ ?	______
Arthritis	❑ Yes	❑ No	❑ ?	______
Cancer	❑ Yes	❑ No	❑ ?	______
Diabetes	❑ Yes	❑ No	❑ ?	______
Heart Disease	❑ Yes	❑ No	❑ ?	______
High Blood Pressure (Hypertension)	❑ Yes	❑ No	❑ ?	______
Kidney Disease	❑ Yes	❑ No	❑ ?	______
Lupus	❑ Yes	❑ No	❑ ?	______
Thyroid Disease	❑ Yes	❑ No	❑ ?	______
Other	❑ Yes	❑ No	❑ ?	______

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)

Do you drive? ❑ Yes ❑ No If yes, do you have visual difficulty when driving ❑ Yes ❑ No

If yes, please describe:______

Do you use tobacco? ❑ Yes ❑ No If yes, type/amount/how long:______

Do you drink alcohol? ❑ Yes ❑ No If yes, how often:______

Do you use illegal drugs? ❑ Yes ❑ No If yes, type/amount/how long:______

Have you ever been exposed to or infected with HIV? ❑ Yes ❑ No

Health History

Do you currently, have any problems in the following areas:

ALLERGY ❑ Yes ❑ No

CARDIOVASCULAR
- Heart Trouble ❑ Yes ❑ No
- High Blood Pressure ❑ Yes ❑ No

CONSTITUTIONAL
- Fever ❑ Yes ❑ No
- Weight Loss ❑ Yes ❑ No
- Weight Gain ❑ Yes ❑ No

CRANIAL / FACIAL
- Chronic Cough ❑ Yes ❑ No
- Dry Mouth ❑ Yes ❑ No
- Ear Infection ❑ Yes ❑ No
- Sinus Congestion ❑ Yes ❑ No

ENDOCRINE
- Diabetes ❑ Yes ❑ No
- Thyroid/Other Glands ❑ Yes ❑ No

GASTROINTESTINAL
- Constipation ❑ Yes ❑ No
- Diarrhea ❑ Yes ❑ No
- Hepatitis ❑ Yes ❑ No

GENITOURINARY
- Bladder ❑ Yes ❑ No
- Kidney ❑ Yes ❑ No

HEMATOLOGIC / LYMPHATIC
- Anemia ❑ Yes ❑ No
- Bleeding Problems ❑ Yes ❑ No

IMMUNOLOGIC
- Syphilis ❑ Yes ❑ No

INTEGUMENTARY (Skin) ❑ Yes ❑ No

MUSCULOSKELETAL
- Arthritis / Rheumatoid ❑ Yes ❑ No
- Joint Pain ❑ Yes ❑ No
- Muscle Pain ❑ Yes ❑ No

NEUROLOGICAL
- Headaches ❑ Yes ❑ No
- Migraines ❑ Yes ❑ No
- Seizures ❑ Yes ❑ No

PSYCHIATRIC ❑ Yes ❑ No

RESPIRATORY
- Asthma ❑ Yes ❑ No
- Bronchitis ❑ Yes ❑ No
- Emphysema ❑ Yes ❑ No

Our doctors routinely perform pupillary dilations and visual field testing. These tests allow our doctors to rule out retinal disease and check for Cataracts, Macular Degeneration, Glaucoma, and other visual pathway diseases that may lead to loss of sight. There is an additional fee of $22.00 for these diagnostic tests. This service may not be covered by some insurance plans.

Please check one of the following:

❑ OK to perform tests today ❑ I will reschedule these tests ❑ I will follow the doctor's recommendation

Professional fees are due upon completion of services and are non refundable.

Thank you for the privilege of allowing Nationwide Vision to take care of your eye health and vision needs.

Patient/Guardian Signature:______ Date:______