Medical History Questionnaire

As a result of newly implemented government regulations due to Health Care Reform, we are in the process of going to a paperless record system and ask that you fill out a Medical History Questionnaire for every Eye Examination that you have at Club View Vision Center. In addition, we will be taking new measurements in the pretest portion of your exam. We will ask you to step on a scale for your weight and height and take your blood pressure as well. All of these can be contributing factors that lead to diseases of the eye such as diabetic retinopathy, glaucoma, hypertension, and thyroid disorders. We think taking these measurements allow us to provide you with the best possible examination. As always, you can refuse to take any portion of the pretest that you do not think is necessary. Rest assured that the answers to these questions will be kept confidential. If you think any questions are too sensitive to be written down, you can discuss them with the doctor in the exam room.

Patient's Name: First_____ M.I. _____ Last _____ Today's Date: _____

Birth Date: _____/_____/_____ Social Security #: _____/_____/_____ Employer: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Daytime Phone:_____ Cell Phone:_____ Texting OK? □ Yes □ No

What is your email address? _____

What is your preferred language? _____ What is your preferred communication? □ Email □ Postal □Telephone

What is your race?
□ American Indian or Alaska Native □ Asian □ Black or African American □ Hispanic □ Native Hawaiian/Other Pacific Islands □ White

If your last eye exam was not at Club View Vision Center, when was your last eye exam? _____

Do you wear glasses? □ Yes □ No Do you wear contact lenses? □ Yes □ No If yes, what brand or type? _____

Current Medical Doctor: _____ City: _____ Last Medical Exam: _____

If this patient is a minor, who is the parent or guardian? _____

Do you have vision insurance? □ Yes □ No If yes, what company? _____

Review of Systems Do you have any problems in the following areas:

System	Yes	No
Medication Allergies:		
_____		
_____		
_____		
_____		
_____		
Cardiovascular:		
Arrhythmia	□	□
Elevated Cholesterol	□	□
High Blood Pressure	□	□
Stroke	□	□
Other _____		
Constitutional:		
Constipation	□	□
Fever	□	□
Weight Gain	□	□
Weight Loss	□	□
Other _____		
Endocrine:		
Diabetes	□	□
Pituitary Disorder	□	□
Renal Disease	□	□
Thyroid Disorder	□	□
Other _____		
Gastrointestinal:		
Acid-Reflux	□	□
Colitis	□	□
Diarrhea	□	□
Gastritis	□	□
Other _____		

System	Yes	No
Genitourinary:		
Bladder Infection	□	□
Kidney Stones	□	□
Ovarian Cyst	□	□
Prostate Disorder	□	□
Other _____		
Ears, Nose, Mouth, Throat:		
Chronic Cough	□	□
Dry Mouth	□	□
Hearing Impaired	□	□
Sinusitis	□	□
Other _____		
Hematologic/Lymphatic:		
Anemia	□	□
Coagulation Disorder	□	□
Sickle Cell Anemia	□	□
Varicose Veins	□	□
Other _____		
Immunologic:		
Bacterial Infection	□	□
Histoplasmosis	□	□
Rubella	□	□
Tuberculosis	□	□
Other _____		
Integumentary (Skin):		
Acne	□	□
Dermatitis	□	□
Psoriasis	□	□
Warts	□	□
Other _____		

System	Yes	No
Musculoskeletal:		
Arthritis	□	□
Myasthenia Gravis	□	□
Osteoporosis	□	□
Scoliosis	□	□
Other _____		
Neurological:		
Epilepsy	□	□
Headache	□	□
Parkinson's Disease	□	□
Seizures	□	□
Other _____		
Psychiatric:		
Alzheimer's	□	□
Anxiety Disorder	□	□
Attention Disorder (ADD)	□	□
Depression	□	□
Other _____		
Respiratory:		
Asthma	□	□
Bronchitis	□	□
COPD	□	□
Emphysema	□	□
Other _____		
Cancer:	□	□
If yes, what type?		
_____		

Social History

Tobacco Use:

□ Never Smoked □ Former Smoker □ Current Everyday Smoker □ Current Someday Smoker □ Current Smokeless Tobacco User

If you currently smoke, how many packs a day? _____ How many years have you smoked? _____

If former smoker, when did you stop smoking?

□ Within Last Year □ 1-2 Year Ago □ 3-4 Years Ago □ 4-5 Years Ago □ 5+ Years Ago □ 10+ Years Ago

Alcohol Use:

□ None □ Social Use Only □ 1-2 Drinks Daily □ Above Average Use □ Alcohol Dependence

Sexually Transmitted Disease:

□ None □Yes □ HIV Positive

Narcotic Drug Use:

□ None □ Recreational Use □ Chemical Dependence

Medical History

□ Check here if you prefer to provide us a list of medications to copy.

List any medications you take: _____

_____

List any surgeries you have had (ocular or systemic): _____

_____

Family History

Have any of your relatives, living or deceased, had any of these conditions? If a grandparent, please specify maternal or paternal.

□ Check here if you do not know your family history.

Ocular Disease/Condition	**Yes**	**No**	**Not Sure**	**Relationship To You**
Blindness	□	□	□	_____
Cataract	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment/Disease	□	□	□	_____
Retinitis Pigmentosa	□	□	□	_____
Other _____	□	□		_____
Systemic Disease/Condition				
Arthritis	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Kidney Disorder	□	□	□	_____
Thyroid Disease	□	□	□	_____
Other _____	□	□		_____

What is the reason for your visit today?

_____

□ Check here if you are having no vision issues at this time.

□ Routine Eye Exam

I request that payment of authorized insurance benefits be made directly to Club View Vision Center, Inc. for any service furnished to me. I authorize release to the Health Care Financing Administration and it's agents medical information about me needed to determine these benefits payable for related services. I authorize Club View Vision Center, Inc. to release any medical information necessary for insurance claim submission and request that payment of medical benefits be made directly to Club View Vision Center, Inc. for services rendered. I have also been given access to a copy of Club View Vision Center's Notice of Privacy Practices.

_____ _____

Patient/Guardian Signature Date