

Medical History Questionnaire

As you may know, there have been newly implemented government regulations for insurance companies. These new regulations are the source of many of the questions on this form and we are required to ask them in order to be reimbursed for your exam and materials. We realize that some questions are very personal in nature and we do not take that lightly at Club View Vision Center. Rest assured that the answers to these questions will be kept confidential and only be used to provide you the best possible exam. 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: _____

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

Are you the parent or guardian of any other patients here? Yes No If yes, who? _____

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	System	Yes	No	System	Yes	No
Allergy:			Genitourinary:			Musculoskeletal:		
Environmental	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>
Pollen	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian Cyst	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			Other _____			Other _____		
Cardiovascular:			Ears, Nose, Mouth, Throat:			Neurological:		
Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bell's Palsy	<input type="checkbox"/>	<input type="checkbox"/>
Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			Other _____			Other _____		
Constitutional:			Hematologic/Lymphatic:			Psychiatric:		
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Coagulation Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			Other _____			Other _____		
Endocrine:			Immunologic:			Respiratory:		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Bacterial Infection	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Pituitary Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Histoplasmosis	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			Other _____			Other _____		
Gastrointestinal:			Integumentary (Skin):			Cancer:		
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what type?	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Gastritis	<input type="checkbox"/>	<input type="checkbox"/>	Warts	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Other _____			Other _____			_____		

Social History

Tobacco Use:

None Former Smoker Light Smoker <1 Pack/Day Average Smoker 1-2 Packs/Day Heavy Smoker >2 Packs/Day

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinitis Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>		_____
Systemic Disease/Condition				
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>		_____

Eyes

Have you had any problems in the following areas with your eyes? (Check all that apply)

- None
- Allergies
- Blurred Vision – Near
- Blurred Vision – Distance
- Burning
- Discharge
- Discomfort/Sore
- Distorted Vision
- Double Vision
- Dry Eye
- Drooping Eyelid
- Twitching Eyelid
- Flashes
- Floaters
- Foreign Body
- Glare
- Halos
- Head Tilt
- Headaches
- Itching
- Light Sensitivity
- Loss of Side Vision
- Ocular Fatigue
- Pain
- Redness
- Sandy/Gritty Feeling
- Vision Loss
- Watery Eyes

Other _____

What is the reason for your visit today? (Check all that apply)

- Check here if you are having no vision issues at this time.
- New Glasses or Contacts
- Routine Eye Exam
- Blurred Vision at Night
- Blurred Distance Vision
- Blurred Near Vision
- Cataract
- Diabetes
- Double Vision
- Dry Eye
- Eye Strain/Fatigue
- Flashes
- Floaters
- Foreign Body Sensation
- Glaucoma
- Headache
- Itching
- Macular Degeneration
- Pain or Discomfort
- Scratchy Gritty Eye
- Strain at Computer
- Watery Eyes

Other _____