MEDICAL HISTORY QUESTIONNAIRE

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Original Date Completed

PATIENT INFORMATION:

Name: ______________________ Occupation: ______________________ ☐ Male

Date of Birth: ______________________ SSN: ______________________ ☐ Female

Address: ______________________

City: ______________________ State: __________ ZIP: __________

Phone: ______________________ Preferred e-mail: ______________________

Cell: ______________________ Ok to text? ☐ Yes ☐ No Ok to email? ☐ Yes ☐ No

PRIMARY CARE PHYSICIAN:

Doctor: ______________________ Last Exam Date: __________

Location: ______________________ Phone: __________

PERSONAL HISTORY:

▪ Do you have any known *allergies* to medication? ☐ Yes ☐ No If yes, list them: ______________________

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▪ Do you currently take any medication? (including eye drops, vitamins, over-the-counter meds, contraceptives, home remedies):
☐ No ☐ Yes, please list: ______________________

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▪ Have you had any major injuries, surgeries, or hospitalizations? ☐ No ☐ Yes, please list: ______________________

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▪ Have you had any eye-related problems? (e.g. crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, cataracts, retinal detachment, infection / injury): ☐ No ☐ Yes, please list: ______________________

▪ Have you ever had a routine eye exam? ☐ Yes ☐ No → ▪ Most recent exam date: __________

▪ Are you currently pregnant or nursing? ☐ Yes ☐ No

▪ Do you currently wear eyeglasses? ☐ Yes ☐ No

▪ Do you currently wear contact lenses? ☐ Yes ☐ No → ▪ Type of contacts? ☐ RGP ☐ Soft ☐ Other

▪ Are they comfortable? ☐ Yes ☐ No

FAMILY HISTORY:

▪ Check off one box for *each* of the following areas to indicate *family* history of illness. Please take into consideration any blood relatives, living or deceased:

Yes	No	?		Yes	No	?		Yes	No	?	
☐	☐	☐	Blindness	☐	☐	☐	Retinal Disease/Detachment	☐	☐	☐	High Blood Pressure
☐	☐	☐	Cataract	☐	☐	☐	Arthritis	☐	☐	☐	Kidney Disease
☐	☐	☐	Crossed Eyes	☐	☐	☐	Cancer	☐	☐	☐	Lupus
☐	☐	☐	Glaucoma	☐	☐	☐	Diabetes	☐	☐	☐	Thyroid Disease
☐	☐	☐	Macular Degeneration	☐	☐	☐	Heart Disease	☐	☐	☐	Other: __________

▪ Additional comments: ______________________

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(Please see reverse side…)

SOCIAL HISTORY:

☐ *(Check here if you would prefer to discuss your social history with the doctor. Please note that all information is kept strictly confidential.)*

- Do you have visual difficulty driving? ☐ Yes ☐ No ☐ N/A
- Do you use tobacco products? ☐ Yes ☐ No
- Do you drink alcohol? ☐ Yes ☐ No
- Do you use illegal drugs? ☐ Yes ☐ No
- Check off any of these social diseases you may have: ☐ HIV ☐ Gonorrhea ☐ Hepatitis ☐ Syphilis

REVIEW OF SYSTEMS:

- Check off one box for *each* of the following areas to indicate any problems you experience, currently or otherwise:

Yes	No	?	**Constitutional**
☐	☐	☐	Fever
☐	☐	☐	Weight Loss / Gain

Yes	No	?	**Eyes**
☐	☐	☐	Loss of Vision
☐	☐	☐	Blurred Vision
☐	☐	☐	Distorted Vision / Halos
☐	☐	☐	Loss of Side Vision
☐	☐	☐	Double Vision
☐	☐	☐	Dryness
☐	☐	☐	Mucous Discharge
☐	☐	☐	Redness
☐	☐	☐	Sandy / Gritty Feeling
☐	☐	☐	Itching
☐	☐	☐	Burning
☐	☐	☐	Foreign Body Sensation
☐	☐	☐	Excess Tearing / Watering
☐	☐	☐	Glare / Light Sensitivity
☐	☐	☐	Eye Pain / Soreness
☐	☐	☐	Chronic Eye/Lid Infection
☐	☐	☐	Stye / Chalazion
☐	☐	☐	Flashes / Floaters
☐	☐	☐	Tired Eyes

Yes	No	?	**Neurological**
☐	☐	☐	Headaches
☐	☐	☐	Migraines
☐	☐	☐	Seizures

Yes	No	?	**Ears, Nose, Mouth, Throat**
☐	☐	☐	Allergies / Hay Fever
☐	☐	☐	Sinus Congestion
☐	☐	☐	Runny Nose
☐	☐	☐	Post-Nasal Drip
☐	☐	☐	Chronic Cough
☐	☐	☐	Dry Mouth / Throat

Yes	No	?	**Gastrointestinal**
☐	☐	☐	Diarrhea
☐	☐	☐	Constipation

Yes	No	?	**Endocrine**
☐	☐	☐	Thyroid / Other Glands

Yes	No	?	**Respiratory**
☐	☐	☐	Chronic Bronchitis
☐	☐	☐	Emphysema
☐	☐	☐	Asthma

Yes	No	?	**Vascular/Cardiovascular**
☐	☐	☐	Diabetes
☐	☐	☐	Heart Pain
☐	☐	☐	High Blood Pressure
☐	☐	☐	Vascular Disease

Yes	No	?	**Bones, Joints, Muscles**
☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	Muscle Pain
☐	☐	☐	Joint Pain

Yes	No	?	**Lymphatic, Hematologic**
☐	☐	☐	Anemia
☐	☐	☐	Bleeding Problems

Yes	No	?	**Genitourinary**
☐	☐	☐	Genitals
☐	☐	☐	Kidney / Bladder

Yes	No	?	**Integumentary**
☐	☐	☐	Skin

Yes	No	?	**Psychiatric**
☐	☐	☐	General

Assignment of Benefits: I request that payment of authorized Medicare or other assigned insurance be made directly to Eric David Dostal, OD, LLC. I authorize this holder of medical information about me to release to CMS and agents any information to determine benefits payable for related services.

I agree that all co-payments and past due balances are due and payable at the time of service. I understand and agree that if my account is delinquent, I may be turned over to a collection agency.

I acknowledge that I received a copy of **Notice of Privacy Practices** (on display at the front desk):

Patient Name: ______________________________

Signature: ______________________ Date: ______________
(Parent/Guardian if under 18)