

# MEDICAL HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Primary Care Physician's Name: \_\_\_\_\_ Patient's Email Address: \_\_\_\_\_

## PATIENT'S MEDICAL HISTORY

List any medications you are taking (including oral contraceptives, aspirin, over-the-counter medications and home remedies) \_\_\_\_\_

Do you have any allergies to medications:  Yes  No If yes, please list: \_\_\_\_\_

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

For Women: Are you pregnant and/or nursing?  Yes  No

Have you had any of the following eye conditions?

	Yes	No		Yes	No
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Distorted Vision/Haloes	<input type="checkbox"/>	<input type="checkbox"/>
Strabismus (Crossed Eyes)	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Refractive Surgery (LASIK/RK)	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>
Drooping Eyelid	<input type="checkbox"/>	<input type="checkbox"/>	Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Cataract Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Amblyopia (Lazy Eye)	<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>
Eye Infection	<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Retina Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain/Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>

Do you currently, or have you ever had any problems in the following areas?

	Yes	No		Yes	No
Constitutional			Ears, Nose, Mouth, Throat		
Fever, weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary			Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose/Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Neurological			Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine			Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/Cardiovascular		
Psychiatric			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
Bones/Joints/Muscles			Diarrhea/Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary		
Lymphatic/Hematologic			Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>			

Other, please list \_\_\_\_\_

**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

Do you use tobacco products?  Yes  No If yes, type/amount/how long \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, type/amount/how long \_\_\_\_\_

Do you use illegal drugs?  Yes  No If yes, type/amount/how long \_\_\_\_\_

Indicate if you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

**FAMILY HISTORY** (Please note any family history: parents, grandparents, siblings, children, living or deceased)

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**EMERGENCY MEDICAL CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address / City \_\_\_\_\_ Telephone \_\_\_\_\_

**INSURANCE SIGNATURE ON FILE**

I certify that the information given by me in applying for insurance payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment from my insurance provider, and I request that payment of these benefits be made on my behalf to Sandra Davidson, O.D., Inc. for any services and materials furnished. I authorize Dr. Davidson to release medical information about me to my insurance provider for determination of my benefits. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**RELEASE OF EXAMINATION FINDINGS**

I authorize Sandra Davidson, O.D., Inc. to send a report of my examination to my physician, referring doctor and/or referring Health Professional

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize Sandra Davidson, O.D., Inc. to discuss the results of my examination to the following individuals. (Please be sure to list spouse, parents, sons/daughters, caregivers etc.)

Name	Relationship
_____	_____
_____	_____
_____	_____

Yes  No I authorize messages to be left on my telephone answering machine.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**RECEIPT OF PATIENT CONFIDENTIALITY POLICY**

I have received Sandra Davidson, O.D., Inc.'s patient confidentiality policy.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_