

# Medical History Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Work Phone: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Dr.'s Phone: \_\_\_\_\_

Email Address \_\_\_\_\_ Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Medical History

Do you have any allergies to medications?  no  yes If yes, explain: \_\_\_\_\_

List any medications you take (including):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all major injuries, surgeries: \_\_\_\_\_  
 \_\_\_\_\_

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections or eye injury, other: \_\_\_\_\_

Are you pregnant and/or nursing?  no  yes  
 Do you wear glasses?  no  yes If yes, how old is your present pair of lenes? \_\_\_\_\_  
 Do you wear contact lenses?  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_  
 Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  yes  no

## Family History

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<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"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<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"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

# 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?  no  yes If yes, do you have visual difficulty when driving?  no  yes

How many hours a day do you use a computer / digital device? \_\_\_\_\_

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

Do you drink alcohol?  no  yes

Do you use recreational drugs?  no  yes

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

# Review of Systems

Do you currently, or have you ever had any problems in the following areas: Circle the current conditions.

SYSTEM	NO	YES	?		NO	YES	?
<b>CONSTITUTIONAL</b>							
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>INTEGUMENTARY (Skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGICAL</b>				Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>RESPIRATORY</b>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES</b>				<b>VASCULAR / CARDIOVASCULAR</b>			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GASTROINTESTINAL</b>			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye strain with Computer Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IBS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GENITOURINARY</b>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BONES / JOINTS / MUSCLES</b>			
Glare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LYMPHATIC / HEMATOLOGIC</b>			
History of Eye infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>ALLERGIC / IMMUNOLOGIC</b>			
Floater in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>				Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>PSYCHIATRIC</b>			
<b>EARS, NOSE, MOUTH, THROAT</b>				Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have a condition not listed above, please list below.

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Doctor's Signature

Date

## **Insurance Information**

**\*\*\*Please read thoroughly and initial where applicable.\*\*\***

### **Vision Insurance**

Covers a routine vision exam. Your plan may also have a benefit for eyeglasses and/or contacts lenses. Depending on your insurance you may have a co-pay for these benefits, *this fee varies*.

### **Medical Insurance**

Filed if a medical condition is diagnosed by the doctor, or if you have any systemic health conditions that could have ocular complications (Ex: Glaucoma, cataracts, eye infections, dry eye, diabetes, ect.). Medical diagnosis often requires additional diagnostic testing. \* We will request your medical card to scan into your file.\*

**I understand I am responsible for payment of all services rendered by the doctor and products purchased at this office.**

\*Initial

\_\_\_\_\_

**I have been presented a copy of the HIPPA Privacy act and understand my rights as a patient, I also know that at any time I can request a hard copy of the HIPPA Privacy Act.**

\*Initial

\_\_\_\_\_

### **Dilation**

Dilation of the pupils allows a more comprehensive examination of the retina, including the peripheral retina, which cannot be seen without dilation. You will experience increased sensitivity to light and blurred near vision. *There is no extra fee for this.*

I wish to have my eyes dilated today. \* Initial here: \_\_\_\_\_

-Or-

I decline having my eyes dilated today. \* Initial here: \_\_\_\_\_

**\*\*\*I have read, acknowledged and understand the above information.\*\*\***

Print: \_\_\_\_\_

Sign: \_\_\_\_\_

Date: \_\_\_\_\_

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## **Optomap: An Ultrawide Digital Image of the Retina**

The optometrists at Delaware Vision Care highly recommend for all patients to have a digital image of the retina done annually with our new scanning imaging system. The non-invasive Optomap enables your doctor to see a much more extensive and detailed view of the back of your eye.

This will allow for important comparisons in future. The Optomap is only a \$20.00 co-pay, reduced from the standard \$39.00 fee (not covered by insurance). Please direct any questions you may have to your optometrist.

\*\*\*The Optomap can detect problems such as macular degeneration, glaucoma, retinal holes and detachments, and diabetic retinopathy. Early detection is crucial.

I would like the Optomap image of my eyes.

\*Initial here: \_\_\_\_\_

I do not want the Optomap image of my eyes.

\*Initial here: \_\_\_\_\_

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