MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Birth Date: _____/_____/_____ Today's Date: _____/_____/_____

Status: ☐ single ☐ married ☐ divorced ☐ widowed

Race: _____ Ethnicity: _____ Gender: _____

How may we contact you? Please check those that apply.
☐ home ☐ cell ☐ work ☐ email ☐ text

Do you need a guardian or power of attorney present? Y / N

Is the patient enrolled in a hospice care program? Y / N

In case of an emergency, whom do we contact?

_____Phone: (_____) _____-_____

Insurance Policy Owner: _____

HIPPA Policy:
I understand Eye Associates of Little River, LLC participates in HIPPA compliance and I have access to my HIPPA rights and office policy. I understand that Eye Associates of Little River, LLC will provide any protected health information that I request with my expressed written permission. **Initial:** _____

Please list the name and relationship of individuals to whom we may release your protected health information.

- _____
- _____

Policy Owner Birth Date: _____/_____/_____ **Policy Owner SS #**_____-_____-_____ **Relationship:** Self / Spouse / Child

Last Eye Doctor: _____ Last Eye Exam: _____/_____
City / State Month Year

Current Medical Doctor: _____ Last Medical Exam: _____/_____
City / State Month Year

Social History

Do you drive? ☐ yes ☐ no If yes, do you have any visual difficulty when driving? ☐ yes ☐ no
Are you currently pregnant or nursing? ☐ yes ☐ no
Do you use tobacco products? ☐ yes ☐ no
Do you use recreational drugs? ☐ yes ☐ no
Have you even had to seek help for substance abuse? ☐ yes ☐no Explain:_____
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ Chlamydia ☐ Syphilis ☐ HIV

Personal Eye History

Check all that apply to you:

☐ Reading Difficulty	☐ Crossed Eyes	☐ Glaucoma
☐ Lazy Eye	☐ Diabetic Bleeding	☐ Cataracts
☐ Eye Injury	☐ Glare at night	☐ Dry Eyes
☐ Double Vision	☐ Itchy/ Watery eyes	☐ Macular Degeneration
☐ Glare and Halos	☐ Poor night vision	☐ Light sensitivity
☐ Floaters	☐ Ocular migraines	☐ _____
☐ Recurrent styes	☐ Dry Eye Syndrome	☐ _____

Do you wear prescription glasses? ☐ yes ☐ no Do you wear drug store reading glasses? ☐ yes ☐ no

Do you have history of needing **PRISM** in your prescription glasses for double vision / vision therapy? ☐ yes ☐ no

Do you wear contact lenses? ☐ yes ☐ no If yes, ☐ soft ☐ hard Brand? _____ How Old? _____

Have you had any eye surgeries?

☐ LASIK / RK / PRK	☐ Muscle Surgery	☐ Glaucoma Surgery
☐ Cataract	☐ Diabetic Laser	☐ Retinal Detachment
☐ Eye Injections	☐ Eyelid Lift	☐ Punctal Plugs

Family vision history:

☐ Blindness	☐ Cataract	☐ Glaucoma	☐ Macular Degeneration dry / wet
☐ Lazy Eyes	☐ Crossed Eyes	☐ Fuchs' Dystrophy	☐ Other_____

Medical History:

Please list any major surgeries, hospitalizations, and/or serious accidents:

_____

_____

_____

_____

Auto Immune

- ☐ Rheumatoid Arthritis ☐ Sarcoidosis ☐ Sjogren's Syndrome ☐ Lupus
- ☐ Crohn's Disease ☐ Lyme Disease ☐ Fibromyalgia ☐ Psoriatic Arthritis

Neurological / Brain

- ☐ Epilepsy or seizures ☐ Dementia ☐ Stroke ☐ Alzheimer's
- ☐ Migraine headaches ☐ Pseudotumor ☐ Multiple Concussions

Cardiovascular

- ☐ High Blood Pressure ☐ Heart Attack ☐ A-Fib ☐ High Cholesterol

Endocrine

- ☐ Diabetes ☐ Thyroid ☐ Grave's Disease ☐ PCOS

Mental Health / Behavioral

- ☐ Depression ☐ ADHD ☐ Autism Spectrum ☐ Bipolar Disorder
- ☐ Anxiety disorder ☐ Chemical Imbalance ☐ _____

Respiratory

- ☐ Asthma ☐ COPD / Emphysema ☐ Chronic Bronchitis ☐ Tuberculosis

Skin

- ☐ Eczema ☐ Psoriasis ☐ Rosacea ☐ Acne ☐ Cancer

Ear / Nose / Throat

- ☐ Sinus problems ☐ Chronic Allergies ☐ Sleep Apnea

Gastrointestinal

- ☐ GERD / Acid Reflux ☐ IBS

Kidney / Bladder:

- ☐ Recurrent UTI ☐ Kidney Stones ☐ Kidney Disease

Lymphatic/ Hematological

- ☐ Anemia ☐ Bleeding / Clotting ☐ Lymphoma ☐ Leukemia

Cancer – any organ: _____

Other (please describe): _____

**********DO NOT WRITE BELOW THIS LINE (Doctor's Comments)**********

I have reviewed this history with the patient as documented above: _____

Doctor's Signature / Date

_____

_____

_____

_____

_____

_____