Medical History Questionnaire

Name:_____ Tel. #_____
Birth Date:__/__/___Address:_____ Zip Code:_____
Place of Employment:_____ Tel. #_____
Vision Ins._____ S.S.N. / I.D._____
Medical Ins. HMO/PPO:_____ I.D._____

Medical Information

How is your general health?
Do you have problems with any of these systems?

Eyes	Y/N	Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N		
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N		
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic/Immunologic	Y/N		

Please explain:_____
Please answer all that apply.

Diabetes Y/N Type:_____ Date of Diagnosis:_____
Allergies Y/N Allergic to what?_____ What happens?_____
Medication Allergy Y/N Which medications:_____
Headaches Y/N How often?_____ Location?_____
Other Health problems:_____
Current Medications:_____
Have you had any operations? Type and when:_____
Do you smoke cigarettes? Y/N How much? _____ Alcohol?_____ Other substances?_____
Name of family/Primary Doctor_____ Date of last visit:_____
Are you pregnant? Y/N What trimester are you in?_____ Are you nursing? Y/N

Family History

High Blood Pressure	Y/N	Relation_____		Macular Degeneration	Y/N	Relation_____	
Diabetes	Y/N	Relation_____		Retinal Detachment	Y/N	Relation_____	
Glaucoma	Y/N	Relation_____		Cataracts	Y/N	Relation_____	
Other eye condition(s)	Y/N	What kind?_____				Relation_____	

Personal Eye Information

Have you had any eye operations? Y/N Type:_____ Date:_____
Have you had any eye injuries? Y/N Kind:_____ Date:_____
Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred Vision? Y/N
Other eye problems? Y/N What kind?_____
Do you currently see an Ophthalmologist? Y/N Who/Where?_____
Do you wear glasses? Y/N Contacts? Y/N Type/Parameters?_____ Are you interested in Contacts? Y/N
Have you had Laser surgery? Y/N Are you interested in Laser surgery? Y/N
Whom may we thank for referring you?_____

I hereby assign all medical benefits, to include all major medical benefits to which I am entitled, including medicare, private insurance, and any other health plans to Dr. Chris Sween, O.D. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. I agree that I am responsible for my bill regardless of whether my insurance pays or denies my claim.

Patient's signature:_____ Date:_____ Doctor's Initials:_____