MEDICAL HISTORY QUESTIONNAIRE   Date____________

Name   M or F   Date of Birth   Social Security #

Address   City/State/Zip   Email Address

Phone   Alternate phone (work , cell)   Date of Last Eye Exam and Drs. Name

Date of last Medical exam   Name of Medical Dr and Phone #

Single ☐ Married ☐ ____
Spouses name, or person to contact in case of emergency

How did you hear about us?____

Primary Insurance   Member Name   Member ID#   Group#

Members address   Members Phone   Members Date of Birth

Members Employer

Secondary Insurance____ ______________
Member name and Address.   Date of Birth

____
Insurance ID#   Group #   Name of Plan   Employer

____
Name of Parent or Guardian (if under 18 years of age)

Medical History

Do you have any allergies to medications? □No □Yes If yes, Explain:____

____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):___________

____

____

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

____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease,

cataracts, eye infections, or eye injury:____

Are you pregnant and/ or nursing? □ no □ yes
Do you wear glasses? □ no □ yes If yes, how old is your present pair of lenses?_____________________________
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

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

Disease/Condition	No	Yes	?	Relationship to you
Blindness	☐	☐	☐	____________________
Cataract	☐	☐	☐	____________________
Crossed Eyes	☐	☐	☐	____________________
Glaucoma	☐	☐	☐	____________________
Macular Degeneration	☐	☐	☐	____________________
Retinal Detachment	☐	☐	☐	____________________
Arthritis	☐	☐	☐	____________________
Cancer	☐	☐	☐	____________________

Disease/Condition	No	Yes	?	Relationship to you
Diabetes	☐	☐	☐	____________________
Heart Disease	☐	☐	☐	____________________
High Blood Pressure	☐	☐	☐	____________________
Kidney Disease	☐	☐	☐	____________________
Lupus	☐	☐	☐	____________________
Thyroid Disease	☐	☐	☐	____________________
Other____________	☐	☐	☐	____________________

Review of Systems

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

Eyes

Condition			
Loss of Vision	☐ no	☐ yes	☐ ?
Distorted Vision / Halos	☐ no	☐ yes	☐
Dryness	☐ no	☐ yes	☐ ?
Redness	☐ no	☐ yes	☐ ?
Itching	☐ no	☐ yes	☐ ?
Foreign Body Sensation	☐ no	☐ yes	☐ ?
Glare / Light Sensitivity	☐ no	☐ yes	☐ ?
Chronic Infection of eye/ Lid	☐ no	☐ yes	☐ ?
Flashes / Floaters in Vision	☐ no	☐ yes	☐ ?
Blurred Vision	☐ no	☐ yes	☐ ?
Double Vision	☐ no	☐ yes	☐ ?
Mucous Discharge	☐ no	☐ yes	☐ ?
Sandy or Gritty Feeling	☐ no	☐ yes	☐ ?
Burning	☐ no	☐ yes	☐ ?
Excess Tearing / Watering	☐ no	☐ yes	☐ ?
Eye Pain or Soreness	☐ no	☐ yes	☐ ?
Sties or Chalazion	☐ no	☐ yes	☐ ?
Tired Eyes	☐ no	☐ yes	☐ ?

Allergic / Immunologic ☐ no ☐ yes ☐ ?

If you answered YES to any of the above or have a condition not listed, please explain :____________________

____

____

Reviewing Dr.'s Signature_____________________________ Date________________________________

Release to file insurance and acknowledgement of receipt of privacy policy

I understand that professional fees are due at the time services are rendered and that a 50% deposit is required at time of order on all materials. Orders will be held for a maximum of 45 days. After this time all orders will be returned to the lab and the deposit will be forfeited and not refunded.

I understand and agree that insurance payments are an arrangement between my insurance carrier and myself. I authorize this office to prepare any insurance forms to assist me in reimbursement from my insurance company. I authorize that payment be made directly to this office and be credited to my account upon receipt. I authorize this office to release any information required to process any insurance claims.

X Signature____ Date __________________________

I acknowledge that I received a copy of Family Vision Clinic's Notice of Privacy Practices.

X Signature ____ Date ____________________________

Any defective materials must be returned within 60 days. No exceptions