MEDICAL HISTORY QUESTIONNAIRE

Last Name: _____ First Name: _____ Date of Birth: ___/___/___
Address: _____City: _____ State: _____ Zip Code: _____
Home phone: _____ Cell phone: _____ E-mail: _____
Employer: _____ Work phone: _____
Vision Insurance: _____ SSN or ID #: _____
Medical Insurance: HMO PPO _____ ID # _____
How were you referred to our office? insurance doctor another patient internet phonebook other
Please explain: _____

Medical Information

How is your general health? excellent good fair poor
Do you have any problems with any of these systems?

gastrointestinal	yes no	nervous	yes no	mental	yes no
ears/nose/throat	yes no	urinary	yes no	endocrine (glands)	yes no
cardiovascular	yes no	muscles/bones	yes no	blood/lymph	yes no
respiratory	yes no	integumentary (skin)	yes no	allergic/immunologic	yes no

If yes to any, please explain: _____

Please answer all that apply:

Diabetes? yes no type: _____ date of diagnosis: _____
_____
Allergies to medication? yes no which?: _____ reaction? _____
Headaches? yes no how often? _____ What area? _____
High blood pressure? yes no date you had your blood pressure checked last: _____
Other health problems? _____
Current medications: _____
Have you had any operations? yes no kind? _____ when? _____
Do you use cigarettes or tobacco? yes no alcohol? yes no other substances? _____
_____
Are you pregnant? yes no Are you nursing? yes no
Name of primary or family doctor: _____ date of last visit: _____

Family History- Does your family have any of these conditions

High blood pressure? yes no relation: _____ Diabetes? yes no relation: _____
Macular degeneration? yes no relation: _____ Glaucoma? yes no relation: _____
Retinal detachment? yes no relation: _____ Cataracts? yes no relation: _____
Other eye conditions? yes no what kind? _____ relation: _____

Personal Eye Information

Have you had any eye operations? yes no type? _____ date: _____
Have you had any eye injury? yes no kind? _____ date: _____
Do you have glaucoma? yes no cataracts? yes no dry eyes? yes no blurred vision? yes no
macular degeneration? yes no retinal detachment? yes no
Other eye problems? yes no what kind? _____
Do you currently see an ophthalmologist? yes no who? _____ Last visit: _____
Do you wear glasses? yes no contact lenses? yes no interested in contacts lenses? yes no
Have you had laser surgery? yes no Are you interested in laser surgery? yes no

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 *Stamper Optometry Inc.* 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: _____

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