## MEDICAL HISTORY QUESTIONNAIRE

Address:	Last Name:		First Name:			D	ate of Birth:	: <u> </u>	1	
Employer:  Work phone:    Vision Insurance:  SSN or ID #    Hew were you referred to our office? insurance & doctor & another patient & internet & phonebook & othe    Please explain:    Medical Information    How were you general health? excellent & good & fair & poor &    Do you have any problems with any of these systems?    gastrointestinal  yes & no & mervous  yes & no & mental  yes & no &    gastrointestinal  yes & no & muscles/bones  yes & no &  mental  yes & no &    gastrointestinal  yes & no &  miscles/bones  yes & no &  allergic/immunologic yes & no &    lif yes to any, please explain:	Address:	City:				State: Zip Code:				
Vision Insurance:	Home phone:		Cell phone:			_ E-mail:				
How were you referred to our office? insurance & doctor & another patient & internet & phonebook & othe Please explain:	Employer:					Work phon	e:			
How were you referred to our office? insurance & doctor & another patient & internet & phonebook & othe Please explain:	Vision Insurance:					SSN or ID #:				
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 & endocrine (glands) yes & no &    gastrointestinal yes & no & urinary yes & no & endocrine (glands) yes & no &    cardiovascular yes & no & integumentary (skin) yes & no & allergic/immunologic yes & no &    fly est o any, please explain:    Please answer all that apply:    Diabetes? yes & no & type:	How were you referred	to our office'	? insurance <b>d</b> octor (	🕯 anot	her pati	ient 🔹 inter	net 🗯 phor	iebook	. Cother	
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 € respiratory yes € no € integumentary (skin) yes € no € allergic/immunologic yes € no € flyes to any, please explain: 	Please explain:									
Do you have any problems with any of these systems? gastrointestinal yes in o in enrous yes in o mental yes in o i cardiovascular yes in o imuscles/bones yes in o imeduary yes in o i respiratory yes in o integumentary (skin) yes in o illergic/immunologic yes in o i respiratory yes in o integumentary (skin) yes in o illergic/immunologic yes in o i respiratory yes in o integumentary (skin) yes in o illergic/immunologic yes in o i respiratory yes in o integumentary (skin) yes in o illergic/immunologic yes in o i respiratory yes in o integumentary (skin) yes in o illergic/immunologic yes in o i respiratory yes in o integumentary (skin) yes in o illergic/immunologic yes in o i Allergies to any, please explain:			1.4 1.4 C · 4	4						
gastrointestinal  yes < no			-	oor 🕊						
ears/nose/throat  yes < no				.4						
cardiovascular yes the not muscles/bones yes the total blood/lymph yes the terspiratory yes the not integumentary (skin) yes the terspiratory wes the term of terspiratory wes the terspiratory were terspiratory were terspiratory were terspiratory with the terspiratory were term were terspiratory were term were term were term were term of the terspiratory were term terspiratory were term terspiratory were term term terspiratory were term term term term term term term t										
respiratory yes to tintegumentary (skin) yes to allergic/immunologic yes to the first to any, please explain:										
If yes to any, please explain:Please answer all that apply:										
Please answer all that apply:				yes 🗯	no 🗯	allergic/im	imunologic	yes 🕯	🕻 no 🕊	
Allergies to medication? yes in o which?:  reaction?    Headaches? yes in o how often?  what area?    High blood pressure? yes in o idate you had your blood pressure checked last:  Other health problems?    Current medications:	Please answer all that	apply:								
Headaches? yes in no in how often?  What area?    High blood pressure? yes in no indicate you had your blood pressure checked last:	Diabetes? yes <b>¢</b> no <b>¢</b>	type:				da	ate of diagn	osis: _		
High blood pressure? yes \$ no \$ date you had your blood pressure checked last:	Allergies to medication? yes <b>é</b> no <b>é</b> which?:					reaction?				
Other health problems?	Headaches? yes <b>é</b> no	how ofter	ו?			_ What area?				
Current medications:	High blood pressure? y	es 🗯 no 🗯 (	date you had your bloc	od press	sure ch	ecked last:				
Current medications:	Other health problems?									
Do you use cigarettes or tobacco? yes in o is alcohol? yes in o is other substances?    Are you pregnant? yes in o is Are you nursing? yes is no is    Name of primary or family doctor:	Current medications:									
Are you pregnant? yes in o interested in contacts lenses?	Have you had any oper	ations? yes	🗯 no 🗯 kind?			wł	nen?			
Name of primary or family doctor:	Do you use cigarettes c	or tobacco? y	res 🗯 no 🗯 alcohol?	yes 🗯	no 🗯 o	other substa	nces?			
Family History- Does your family have any of these conditions    High blood pressure?  yes the nother relation: Diabetes? yes the nother relation:    Macular degeneration?  yes the nother relation: Glaucoma? yes the nother relation:    Retinal detachment?  yes the nother relation: Cataracts? yes the nother relation:    Other eye conditions?  yes the nother relation?    Personal Eye Information	Are you pregnant? yes	🔹 no 🔹 Ar	e you nursing? yes 🗯	no 🗯						
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 € type?  Cataracts? yes € no € relation:    Personal Eye Information   date:    Have you had any eye operations? yes € no € type?  date:    Do you have glaucoma? yes € no € cataracts? yes € no € dry eyes? yes € no € blurred vision? yes € no €  off    macular degeneration? yes € no € retinal detachment? yes € no €  off    Other eye problems? yes € no € what kind?  Last visit:    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 €					date of last visit:					
Macular degeneration?  yes the notic relation:  Glaucoma? yes the notic relation:    Retinal detachment?  yes the notic relation:  Cataracts? yes the notic relation:    Other eye conditions?  yes the notic relation:  Cataracts? yes the notic relation:    Personal Eye Information  relation:  relation:    Have you had any eye operations? yes the notic type?  date:    Have you had any eye injury? yes the notic kind?  date:    Do you have glaucoma? yes the notic cataracts? yes the notic dry eyes? yes the notic blurred vision? yes the notic cataracts? yes the notic dry eyes? yes the notic blurred vision? yes the notic dry eye problems? yes the notic retinal detachment? yes the notic dry eyes? yes the notic blurred vision? yes the notic dry eye problems? yes the notic match whet kind?    Do you currently see an ophthalmologist? yes the notic who?  Last visit:    Do you wear glasses? yes the notic contact lenses? yes the notic interested in contacts lenses? yes the notic dry eye for the relation?	Family History- Does	your family	have any of these co	ndition	S					
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Have you had any eye operations? yes <b>é</b> no <b>é</b> type? date: Have you had any eye injury? yes <b>é</b> no <b>é</b> kind? date: Do you have glaucoma? yes <b>é</b> no <b>é</b> cataracts? yes <b>é</b> no <b>é</b> dry eyes? yes <b>é</b> no <b>é</b> blurred vision? yes <b>é</b> no <b>é</b> macular degeneration? yes <b>é</b> no <b>é</b> retinal detachment? yes <b>é</b> no <b>é</b> Other eye problems? yes <b>é</b> no <b>é</b> what kind? Do you currently see an ophthalmologist? yes <b>é</b> no <b>é</b> who? Last visit: Do you wear glasses? yes <b>é</b> no <b>é</b> contact lenses? yes <b>é</b> no <b>é</b> interested in contacts lenses? yes <b>é</b> no <b>é</b>										
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Have you had any eye injury? yes	Have you had any eye	operations?	yes 🗯 no 🗯 type?				date:			
Do you have glaucoma? yes										
macular degeneration? yes <b>é</b> no <b>é</b> retinal detachment? yes <b>é</b> no <b>é</b> Other eye problems? yes <b>é</b> no <b>é</b> what kind? Do you currently see an ophthalmologist? yes <b>é</b> no <b>é</b> who? Last visit: Do you wear glasses? yes <b>é</b> no <b>é</b> contact lenses? yes <b>é</b> no <b>é</b> interested in contacts lenses? yes <b>é</b> no <b>é</b>	Do you have glaucoma	? yes 🗉 no 🤅	🕯 cataracts? yes 🗳 n	o 🗯 dry	/ eyes?	' yes 🗯 no	🗯 blurred 🗤	ision?	yes 🕊	
Other eye problems? yes <b>é</b> no <b>é</b> what kind? Do you currently see an ophthalmologist? yes <b>é</b> no <b>é</b> who? Last visit: Do you wear glasses? yes <b>é</b> no <b>é</b> contact lenses? yes <b>é</b> no <b>é</b> interested in contacts lenses? yes <b>é</b> no <b>é</b>										
Do you wear glasses? yes & no & contact lenses? yes & no & interested in contacts lenses? yes & no &	macular degeneration?	yes 🕊 no 🕊	retinal detachment? y	es 🕊 no	D 🗳					
Do you wear glasses? yes & no & contact lenses? yes & no & interested in contacts lenses? yes & no &	Do you currently see an	n ophthalmol	ogist? ves ∉ no ∉ wh	10?		:	ast visit <sup>.</sup>			
Have you had laser surgery? yes 🗯 no 🗯 Are you interested in laser surgery? yes 🗯 no 单	Do you wear glasses? y	yes 🗉 no 🗉	contact lenses? yes	🗯 no 🗯	intere	sted in cont	acts lenses	? yes	单 no 单	

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:
Patient's signature:	_date:	_Doctor's initials:
Patient's signature:	date:	Doctor's initials: