Medical History Questionnaire

Patient's Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Gender: ❒ Male ❒ Female ❒ Single ❒ Married
Ethnicity: _____
If Married, Name of Spouse: _____ If Child, Parent's name:_____
Address: _____ City: _____ Zip:_____
Phone: _____ Business Phone: _____ Cell:_____
Email: _____ Patient's SS#:_____
Employer: _____ Occupation: _____
Preferred Method of Contact: ❒ Text ❒ Email ❒ Phone

Insurance Information (If applicable)

Name of Medical Insurance: _____ Subscriber SSN and DOB: _____
Primary Insured: _____ Relationship to Insured: _____
Name of Vision Insurance: _____ Subscriber SSN and DOB: _____
Name of Primary Care Physician: _____ Last Medical Exam: ___/___/___

Date of Last Eye Exam: ___/___/___
Do you wear glasses? _____
Do you wear contact lenses? _____ If yes, do you sleep in them? _____ How often? _____
Are you having any problems with your current glasses or contact lenses? _____
Current Brand/Power of contact lenses: _____

Reason for Today's Visit:
_____
_____

Review of Systems	**Yes**	**No**
Seasonal Allergies	❒	❒
Rheumatoid Arthritis	❒	❒
High Blood Pressure	❒	❒
Heart Disease/Cholesterol	❒	❒
Diabetes	❒	❒
Gastrointestinal	❒	❒
Cancer	❒	❒
Endocrine/Thyroid	❒	❒
Ear/Nose/Throat	❒	❒
Seizures	❒	❒
Urinary/STD	❒	❒
Blood/Lymph Nodes	❒	❒
Psychiatric	❒	❒
Respiratory	❒	❒
Multiple Sclerosis	❒	❒

Family History	**Yes**	**No**
Blindness	❒	❒
Glaucoma	❒	❒
Diabetes	❒	❒
Cataracts	❒	❒
Macular Degeneration	❒	❒
Keratoconus	❒	❒
Retinal Detachment	❒	❒

Ocular History	**Yes**	**No**
Blurred Vision	❒	❒
Cataracts	❒	❒
Strabismus (eye turn)	❒	❒
Double Vision	❒	❒
Eye Infections	❒	❒
Eye Injury/Trauma	❒	❒
Flashes/Floaters	❒	❒
Glaucoma	❒	❒
Macular Degeneration	❒	❒
Retinal Disease	❒	❒
Retinal Detachment	❒	❒
Amblyopia (lazy eye)	❒	❒
Dry Eyes	❒	❒
Iritis	❒	❒
Keratoconus	❒	❒
Diabetic Retinopathy	❒	❒
Optic Nerve Disease	❒	❒

Previous Eye Surgeries	**Yes**	**No**
Cataract	❒	❒
Retinal Detachment	❒	❒
Muscle Surgery	❒	❒
Trauma	❒	❒
LASIK/PRK	❒	❒
Foreign Body Removal	❒	❒

Please explain any **YES** answers:

_____
_____
_____

ALLERGIES (drug, seasonal, food):

_____

CURRENT MEDICATIONS (Rx and over the counter, including eye drops):

_____

_____

Please list any **hospitalizations**, **major surgeries** or **illnesses** (date and type):

_____

_____

Social History (all information is kept strictly confidential):
Do you smoke? ❒ Yes ❒ No If yes, how much? _____
Do you drink alcohol? ❒ Yes ❒ No If yes, how much? _____
Do you use any recreational drugs? ❒ Yes ❒ No If yes, please explain _____
Are you pregnant? ❒ No ❒ Yes ❒ Nursing

How did you learn about our practice?
❒ Established Patient ❒ Insurance ❒ Media (Facebook, Twitter) ❒ If referred, by whom?_____
❒ Live in the neighborhood

Retinal Exam Consent
An important part of your eye exam is the retinal evaluation. It allows the doctor to evaluate your overall health by looking at blood vessels, nerves, and other components inside your eye. The optometrist recommends the Optomap retinal scan technology to accomplish this. The Optomap imaging technology allows the doctor to detect early signs of retinal disorders, including but not limited to: glaucoma, cancer, diabetic retinopathy, high blood pressure, macular degeneration, and retinal detachment. By performing this test, dilation is usually not necessary in most cases. The images will become a part of your permanent medical record and can be viewed at subsequent eye exams to detect subtle changes and monitor your eye health. This procedure is a generally non-covered service unless being used to actively follow ocular disease.

- ❒ I would like **Optomap retinal imaging.** I agree to the $39 fee for service not covered by my insurance.
- ❒ I prefer **dilation with eye drops**. I understand that it will cause light sensitivity and may blur my vision for about 2-4 hours.
- ❒ I **decline both Optomap and dilation** and understand that a comprehensive exam has not been performed.

Please initial the following:
_____ **Consent for Care:** I hereby give consent for treatment to Palo Alto Eyes Optometry.
_____ **Polycarbonate Lenses:** Polycarbonate lenses are the most impact resistant lenses available. They are strongly recommended for patients with compromised vision in one eye, patients who are active in sports, patients who work with power tools, and patients under the age of 18.
_____**Authorization to Leave Message:** I hereby authorize Palo Alto Eyes Optometry to leave messages regarding pending appointments, tests, glasses or contact lenses at the numbers given.

Signature of Patient/Guardian: _____ Date: _____