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 Dr. Seger to evaluate your overall health by looking at blood vessels, nerves, and other components inside your eye. Dr. Seger recommends the Optomap retinal scan technology to accomplish this. The Optomap imaging technology allows Dr. Seger 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 $35 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 The Spectacle Shoppe.
_____ **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 The Spectacle Shoppe to leave messages regarding pending appointments, tests, glasses or contact lenses at the numbers given.

Signature of Patient/Guardian: ______________________________________ Date: ______________