

MEDICAL HISTORY QUESTIONNAIRE

TODAY'S DATE: _____
NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
EMPLOYER: _____
SOCIAL SECURITY #: _____
E-MAIL ADDRESS: _____
EMERGENCY CONTACT NAME: _____

AGE: _____ DATE OF BIRTH: _____
HOME PHONE: _____
WORK PHONE: _____
CELL PHONE: _____
MARITAL STATUS: _____
SEX: MALE FEMALE
PHONE: _____

PARENT/GUARANTOR: _____
ADDRESS (if different): _____
CITY/STATE/ZIP: _____
EMPLOYER: _____
SOCIAL SECURITY #: _____

DATE OF BIRTH: _____
HOME PHONE: _____
WORK PHONE: _____
CELL PHONE: _____
SEX: MALE FEMALE

INSURANCE

VISION: _____
SUBSCRIBERS NAME: _____

MEDICAL: _____
DATE OF BIRTH: _____

I acknowledge that I have been offered a copy of Family Vision Associates Notice of Privacy Practices.

Signature: _____

A 50% deposit on glasses is required before order can be placed, with the balance being paid at dispensing. Any amount not paid for by insurance due to deductibles, copays, rejected claims, etc. shall be the responsibility of the patient/guarantor. I agree to be responsible for any amount not covered by insurance.

Signature: _____
(Patient, Parent or Legal Guardian)

PLEASE FILL OUT MEDICAL QUESTIONNAIRE (Reason for today's visit) BELOW.

REASON FOR TODAY'S VISIT

PATIENT FORM

Problem seeing at distance
Problem seeing at near
Eye strain with near work
Reading/Learning problem
Failed a screening test

Red eyes
Burning eyes
Itching eyes
Tearing eyes
Painful eyes

Dry eyes
Tired eyes
Double vision
Headaches
Other: _____

Concern about Glaucoma
Concern about Cataracts
Concern about Diabetes

REVIEW OF SYSTEMS

(Please select the medical conditions YOU, THE PATIENT are experiencing or have experienced.)

Allergies

SEASONAL

MEDICATIONS

Hematologic/Lymphatic

ANEMIA

LEUKEMIA

LYMPHOMA

Cardiovascular

HEART ATTACK

HIGH BLOOD PRESSURE

Integumentary

ACNE

LUPUS

PSORIASIS

HIGH CHOLESTEROL

STROKE

Musculoskeletal

ARTHRITIS

OSTEOPOROSIS

Constitutional

FAINTING

LOSS OF APPETITE

SCOLIOSIS

WEIGHT GAIN/LOSS

Endocrine

CROHNS DISEASE

DIABETES

Neurological

DYSLEXIA

EPILEPSY

HEADACHES

THYROID DISEASE

MULTIPLE SCLEROSIS

SEIZURES

Gastrointestinal

ACID REFLUX

GALLBLADDER

ULCER

Psychiatric

ADD

ANXIETY

ALZHEIMER'S

Genitourinary

MENOPAUSE

PROSTATE

DEPRESSION

DEMENTIA

Respiratory

ASTHMA

BRONCHITIS

EMPHYSEMA

Any form of Cancer: _____

Other: _____

FAMILY PHYSICIAN NAME: _____ PHONE #: _____

LIST OF MEDICATIONS:

FAMILY HISTORY:

(Please select any condition(s) that apply to IMMEDIATE FAMILY- Parents, Grandparent and Siblings)

Glaucoma
Blindness

Cataracts
Diabetes

Crossed Eyes
Melanoma

"Lazy Eyes"
Macular Degeneration

SOCIAL HISTORY: (Please select any that apply to YOU, THE PATIENT)

Drink Alcohol

Former Smoker

Communicable Disease (HIV, Hepatitis,

Smoke Tobacco -- packs/day _____ how long _____

Syphilis)

Illegal Drug Use