

Vision Care Associates

Medical History Questionnaire

Mr. Mrs. Ms. _____ Today's Date _____
Address _____ Suite/Apt # _____
City _____ State _____ Zip _____
E-mail _____ Last Eye Exam _____ Date of Birth _____
Employer _____ Occupation _____

Describe how you use your vision at work so we can make the best lens recommendations for you:

What kinds of hobbies, sports, and other interests do you have? Knowing this enables us to find the best vision correction for you:

Who can we thank for referring you to our office? _____

Your Personal History

Yes No

- Do you wear contacts? Type/Brand _____
- Are you pregnant or nursing?
- Have you had any major injuries, surgeries and/or hospitalizations? Please list them:

- Do you take any medications? Please list them:

Do you currently have or had the following conditions, check those that apply:

Allergic/Immunologic

- Drug Allergy _____
- Environmental Allergy _____
- Rheumatoid Arthritis

Cardiovascular

- Heart Disease
- Hypertension
- Stroke

General Health

- Developmental Disability
- Head Trauma
- Headaches
- Cancer

Ears, Nose Throat

Endocrine

- Diabetes
- Thyroid

Eyes

- Retinal Detachment
- Glaucoma
- Cataracts
- Macular Degeneration
- Lazy Eye
- Eye Infections
- Eye Injury

Genitourinary

- STD - HIV, Herpes, Chlamydia

Hematologic/Lymphatic

- Anemia
- Leukemia

Dermatologic

- Eczema
- Rosacea
- Psoriasis

Your Personal History Continued ...

Neurological

- Multiple Sclerosis
- Epilepsy

Respiratory

- Asthma
- Emphysema

Muskuloskeletal

- Muscular Dystrophy
- Osteoarthritis
- Ankylosing Spondylitis

Psychiatric

- Depression

- Gastrointestinal

Family History

Does any family member (parents, grandparents, siblings, children) currently have or had any of the following conditions? Please write the relationship to you.

- | | |
|---|--|
| <input type="checkbox"/> Blindness _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Cataract _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Crossed Eyes _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Macular Degeneration _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Retinal Detachment/Disease _____ | <input type="checkbox"/> Other: _____ |

Health History Update

Changes in
medical history?

Yes No

List Changes

Date

Patient Initials

Payment Policy:

We will do all we can to find out what your vision insurance benefits are and what you are eligible for. We will also submit your claim for you. The information given to us by your insurance company is not a guarantee of payment from them. If your insurance company does not pay this amount it will be your responsibility to pay your balance.

To the best of my knowledge, the above information is correct.

Patient's signature or Parent/Guardian

Date