Medical History Questionnaire

Name:_____ Today's Date:_____
Address:_____ Phone:_____
_____ Work Phone:_____
E-mail:_____ Cell Phone:_____
Date of birth:____/____/_____ Social Security #:_____/____/_____ Last Eye Exam: ____/____/_____
Name of Medical Doctor:_____ Last Physical: ____/____/_____
Pharmacy name/address/phone:_____
Occupation:_____ Hobbies:_____

Medical History

Do you have allergies to medications? ☐ No ☐ Yes If yes, explain:

_____
_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications, and vitamins):

_____
_____
_____

List all major injuries, surgeries and/or hospitalizations you have had:

_____
_____

List any of the following you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections, eye injury or eye surgery:

_____
_____

Are you pregnant or nursing? ☐ No ☐ Yes
Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair? _____
Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____
Type of contact lenses: ☐ Rigid ☐ Soft ☐ 1 Day use ☐ Other
Are they comfortable? _____

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Disease	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Other	☐	☐	☐	_____

Social History *(This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)*

[ ] Yes, I would prefer to discuss my social history directly with my doctor. (check box)

Do you use tobacco products? ☐ No ☐ Yes If yes, type/ amount/how long: _____
Are you a former smoker? ☐ No ☐ Yes If yes, how long/date of cessation: _____
Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long: _____
Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long: _____
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis
Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes
If yes, please describe: _____

Review of Systems

Height: ___' ____" Weight: _____lbs

Do you currently or have you ever had any problems in the following areas:

DISEASE/CONDITION	NO	YES	?	DESCRIPTION
Constitutional - (Fever/weight loss/gain)	☐	☐	☐	_____
Integumentary - (Skin)	☐	☐	☐	_____
Neurological - (headaches, seizures)	☐	☐	☐	_____
Endocrine - (Thyroid, Diabetes)	☐	☐	☐	_____
Ear, Nose, Mouth, Throat	☐	☐	☐	_____
Respiratory - (Asthma, Emphysema)	☐	☐	☐	_____
Cardiovascular - (BP, cholesterol)	☐	☐	☐	_____
Gastrointestinal	☐	☐	☐	_____
Bones/Joints/Muscles - (Arthritis)	☐	☐	☐	_____
Genitourinary	☐	☐	☐	_____
Lymphatic/Hematologic - (Anemia)	☐	☐	☐	_____
Allergic/Immunologic	☐	☐	☐	_____
Psychiatric	☐	☐	☐	_____

EYES *(Check all that apply)*

Loss of vision	☐	Burning	☐
Blurred vision	☐	Foreign body sensation	☐
Distorted vision/haloes	☐	Excess tearing/watery eyes	☐
Loss of side vision	☐	Glare/light sensitivity	☐
Double vision	☐	Eye pain or soreness	☐
Dryness	☐	Chronic infection of eye or lid	☐
Mucous discharge	☐	Sties or Chalazion	☐
Redness	☐	Flashes/floaters in vision	☐
Sandy or gritty feeling	☐	Tired eyes	☐
Itching	☐	Computer eye strain	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medications.

_____
_____
_____
_____

How did you hear about us? _____

Doctor's Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

MAIN STREET OPTOMETRY
89 Main Street, Northport NY 11768
(631) 757-6190
Fax: (631) 757-4759

Patient Name: _____

Patient Number: _____ Patient Phone Number: _____

Patient Address: _____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Main Street Optometry.

_____ _____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

Source of Authority: _____