MEDICAL HISTORY QUESTIONNAIRE

Today's Date ____/____/2019

Name: _____ Age: _____ Date of Birth: _____/ _____/ _____

Occupation: _____

Medical Doctor: _____

Please list current medications:

_____ _____

_____ _____

_____ _____

_____ _____

Please list any health conditions or reasons for medications above:
(i.e. Hypertension, Diabetes, Thyroid, etc.)

_____ _____

_____ _____

_____ _____

List any surgeries or laser to your eyes you have had:

_____ _____

Are you allergic to any medications? If so, which ones?:

_____ _____

How old are your glasses? _____

Do you wear contact lens? _____

If yes, what kind? _____

EYE PROBLEMS:

LOSS OF VISION	YES	NO
BLURRED VISION	YES	NO
DISTORTED VISION	YES	NO
DOUBLE VISION	YES	NO
DRYNESS	YES	NO
REDNESS	YES	NO
ITCHING	YES	NO
BURNING	YES	NO
EXCESS TEARING	YES	NO
GLARE/LIGHT SENSITIVITY	YES	NO
EYE PAIN OR SORENESS	YES	NO
FLASHES/FLOATERS	YES	NO
STIES OR CHALAZION	YES	NO
SANDY FEELING	YES	NO
CHRONIC INFECTION	YES	NO
DROOPY EYELIDS	YES	NO
WRINKLES AROUND EYES	YES	NO
TIRED EYES	YES	NO

Patient Name: _____ DOB: _____

We are participating in the government's **Meaningful Use Requirements Program**, which is intended to improve care coordination and ensure security and privacy provisions for personal health information. Please take a moment and fill out the information below.

Please mark the items that apply to you. *You have the right to decline reporting this information.*

RACE

- ❑ Asian
- ❑ American Indian/Alaskan Native
- ❑ Black/African American
- ❑ Native Hawaiian
- ❑ Other Pacific Islander
- ❑ White
- ❑ More than 1 race
- ❑ Decline to Report

ETHNICITY

- ❑ Hispanic/Latino
- ❑ Not Hispanic/Latino
- ❑ Decline to Report

LANGUAGE

❑ English ❑ Spanish ❑ French
❑ Italian ❑ Other ❑ Decline to Report

Preferred Language: _____

SMOKING STATUS

Do you currently smoke? ❑ Yes ❑ No ❑ Decline to report

Email address:_____ (to be used for patient communication only)

Patient Name: _____ DOB: _____

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