



Medical History Questionnaire

Today's Date: ____/____/____

Patient's Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Phone: (H) _____ (W) _____ (Cell) _____ Birth Date: ____/____/____

E-mail: _____ Occupation: _____ Employer: _____

SSN: _____ - _____ - _____ Insurance: _____ Group and ID No.: _____

Emergency Contact Name: _____ Phone: _____

Allergy

Medication Allergies: _____ Environmental/Seasonal Allergies: _____

Please indicate if the you have any of the following conditions:

Cardiovascular

- High Blood Pressure
- High Cholesterol
- Heart Disease

Constitutional/General

- Dizziness
- Recent Sickness (flu, cold)
- Cancer: please explain:

Cranial/Facial

- Hearing Loss
- Sinus Problems

Endocrine

- Diabetes If yes, for how many years? _____
- Thyroid Disease
- Kidney Disease

Gastrointestinal

- Acid Reflux
- Crohn's Disease
- Liver Disease

Genitourinary

- Reiters
- Prostate Cancer
- Menopause

Hematologic/Lymphatic

- Clotting Disorder
- Anemia

Immunologic:

- Herpes Simplex
- Herpes Zoster (Shingles)
- Rheumatoid Arthritis
- Lupus
- Frequent Cold Sores

Integumentary/Skin:

- Rosacea
- Skin Cancer

Neurologic

- Headache/Migraine
- Multiple Sclerosis

Psychiatric

- Depression
- Attention Deficit Disorder
- Dementia

Respiratory:

- Asthma
- COPD
- Bronchitis

Please list other health conditions not mentioned above: _____

Please list your primary care doctor: _____

Please see other side.

Please list medications you are taking: _____

- I use cigarettes/tobacco regularly. I use alcohol regularly. I use other substances.

Family Medical History:

Please indicate if anyone in your family has: *Please indicate if on your maternal or paternal side.*

- | | |
|--|-----------------|
| <input type="checkbox"/> Diabetes | Relation: _____ |
| <input type="checkbox"/> High Blood Pressure | Relation: _____ |
| <input type="checkbox"/> Heart Disease | Relation: _____ |
| <input type="checkbox"/> Cancer | Relation: _____ |
| <input type="checkbox"/> Other | Relation: _____ |

Personal Eye History:

- I have had an eye operation. Which Eye? _____ Type: _____ Date: _____
 I have had an eye injury. Which Eye? _____ Type: _____ Date: _____
 I have glaucoma. I have cataracts. I have macular degeneration. I have dry eyes.
 I have other eye problems: _____

Family Eye History:

Please indicate if anyone in your family has: *Please indicate if on your maternal or paternal side.*

- | | |
|---|-----------------|
| <input type="checkbox"/> Glaucoma | Relation: _____ |
| <input type="checkbox"/> Macular Degeneration | Relation: _____ |

Lifestyle Questionnaire:

- | | |
|---|--|
| <input type="checkbox"/> I wear glasses. | <input type="checkbox"/> I wear contacts. |
| <input type="checkbox"/> I do not wear contacts, but am interested in them. | <input type="checkbox"/> I am interested in new eyeglass frames. |
| <input type="checkbox"/> I am interested in prescription sunglasses. | <input type="checkbox"/> I am interested in laser eye surgery. |

Do you have trouble with:

- | | | |
|---|--|--|
| <input type="checkbox"/> Glare while driving at night | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Eyestrain while working on the computer |
| <input type="checkbox"/> Headaches resulting from eyestrain | | <input type="checkbox"/> Double vision |

To help us get to know you better and to better understand your visual needs, please indicate what hobbies/activities you are interested in:

Whom may we thank for referring you? _____

Please sign below, indicating that (1) you have had the opportunity to read our Notice of Privacy Practices, (2) authorizing the release of medical or other information necessary to process your insurance claim, and (3) authorizing insurance benefits to be paid directly to Sheridan EyeCare Center.

Promise to Pay: I understand that I am responsible for all services provided to me by Sheridan Eyecare and its staff. If I fail to pay for the services when they are rendered or if I fail to pay for services that are not paid by my insurance company, I will be responsible for all costs of collection, including but not limited to, interest at the rate of one and a half percent (1.5%) per month or eighteen percent (18 percent) per year, court costs and fees, attorney fees, and a collection fee of thirty five percent (35%) of the unpaid balance for collection.

Signature