

# Medical History Questionnaire

\* IN ORDER FOR YOUR INSURANCE COMPANY TO BE BILLED, THIS FORM MUST BE FILLED OUT COMPLETELY (FRONT & BACK)\*

Patient's Name: \_\_\_\_\_ Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's Name: \_\_\_\_\_ Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dependent's Name(s): \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Race: \_\_\_\_\_

Home Phone: \_\_ (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Mobile Phone: \_\_ (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_

Patient's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone: \_\_ (\_\_\_\_) \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Vision Insurance: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Medical History

Do you have any allergies to medications?  No  Yes If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): \_\_\_\_\_

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

Circle any of the following that you have had: Crossed Eyes, Lazy Eye, Drooping Eyelid, Prominent Eyes, Glaucoma, Retinal Disease, Cataracts, Eye Infections. ...Are you pregnant and/or nursing? No Yes

### 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____				_____

### Do you.....

	No	Yes
...work at a computer for long periods?	<input type="checkbox"/>	<input type="checkbox"/>
...wear more than one pair of glasses?	<input type="checkbox"/>	<input type="checkbox"/>
...want information on thinner, lighter lenses?	<input type="checkbox"/>	<input type="checkbox"/>
...wear Bifocals?	<input type="checkbox"/>	<input type="checkbox"/>
...spend time outdoors? (how much?)	<input type="checkbox"/>	<input type="checkbox"/>
...have prescription sunglasses?	<input type="checkbox"/>	<input type="checkbox"/>
...have problems with glare or reflection particularly when driving at night?	<input type="checkbox"/>	<input type="checkbox"/>
...have you ever worn/are currently wearing contacts?	<input type="checkbox"/>	<input type="checkbox"/>
...Are you interested in contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
... What time of the day do you become aware of your contacts?		_____
...Rate your contacts overall performance and Vision from 1-10 1-Poor 10- Excellent		_____
Would you be interested in wearing a Daily disposable contact lens occasionally instead of glasses?	<input type="checkbox"/>	<input type="checkbox"/>
Are you planning on getting new glasses today?	<input type="checkbox"/>	<input type="checkbox"/>
Are you planning on getting new contacts today?	<input type="checkbox"/>	<input type="checkbox"/>

\* Please turn this form over and complete other side \*

**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 information directly with my doctor. (Check box)

Do you drive?  No  Yes If yes, do you have visual difficulty when driving?  No  Yes If yes, please describe:

Do you use tobacco products?  No  Yes If yes, type / amount / how long: \_\_\_\_\_

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

**Review of Systems**

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

SYSTEM	No	Yes	?
<b>CONSTITUTIONAL</b>			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>INTEGUMENTARY (Skin)</b>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGICAL</b>			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES</b>			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>LYMPHATIC / HEMATOLOGIC</b>			
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SYSTEM	No	Yes	?
<b>EARS, NOSE, MOUTH, THROAT</b>			
Allergies/ Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VASCULAR / CARDIOVASCULAR</b>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>GASTROINTESTINAL</b>			
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>GENITOURINARY</b>			
Genitals / Kidney / Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>BONES / JOINTS / MUSCLES</b>			
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>			
Thyroid / Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ALLERGIC / IMMUNOLOGIC</b>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>PSYCHIATRIC</b>			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Signature

Date

# SMS Messaging

## OPT-IN CONSENT FORM

"By submitting this form, I consent to receive SMS text messages from Bryant Eyecare Clinic for appointment reminders, marketing messages, and general two-way communication. Msg frequency varies. Msg&data rates may apply. Reply HELP for support. Reply STOP to opt out."

Phone number \_\_\_\_\_

Signature \_\_\_\_\_