Medical History Questionnaire

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Drs. Williams, Gerstberger, Dahl & Hausmann

Name: _____ Today's Date: _____

Birth Date: _____/_____/_____ Last Eye Doctor: _____ Last Eye Exam: _____

Current Medical Doctor (primary care physician):_____ Last Medical Exam: _____

Do you have allergies to medication? Yes No If yes, explain reaction and name of medication: _____

_____

List any medications you currently take including *dosage and frequency* (including oral contraceptives, aspirin, over-the counter medication and home remedies):_____

_____

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

_____

Review of Systems Current Height_____ Weight_____

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

	Yes	No	Unsure
Constitutional			
Fever, excess weight change	☐	☐	☐
Cardiovascular			
Heart problems	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Ears, Nose, Mouth, Throat			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion (frequent)	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Hearing Loss	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Chronic Cough	☐	☐	☐
Emphysema	☐	☐	☐
COPD	☐	☐	☐
Sleep Apnea	☐	☐	☐
Gastrointestinal			
Freq. Diarrhea or Constipation	☐	☐	☐
Genitourinary			
Kidney/Bladder/Prostate	☐	☐	☐
Musculoskeletal			
Frequent Muscle Pain	☐	☐	☐
Frequent Joint Pain	☐	☐	☐
Integumentary (SKIN)			
Skin cancer	☐	☐	☐
Eczema	☐	☐	☐
Neurological			
Frequent Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	Unsure
Psychiatric			
Depression/Anxiety	☐	☐	☐
Endocrine			
Diabetes	☐	☐	☐
Insulin dependent	☐	☐	☐
Non-insulin dependent	☐	☐	☐
Last Hemoglobin A1C _____ Date: _____			
Avg. blood sugar level _____			
Thyroid	☐	☐	☐
Hematologic/Lymphatic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Immunologic			
Rheumatoid Arthritis	☐	☐	☐
Lupus	☐	☐	☐
Organ Transplant	☐	☐	☐
Cancer			
Type: _____			
Treatment: _____ Year of diagnosis_____			

Are you pregnant or nursing? Yes No Due Date: _____

At work: Do you perform fine or up-close work? Yes No

Is safety protection a concern at work? Yes No

Are you outdoors all or part of the time? Yes No

Are you on a computer 4 or more hours per day? Yes No

Are you sensitive to: Bright sunlight Computer screen glare Oncoming headlights

What hobbies or recreational sports do you enjoy? _____

Do you wear glasses? Yes No If yes, how old is your present pair of glasses? _____

How many pair of glasses do you currently use? _____

Do you wear contact lenses? Yes No If yes, how old is your present pair? _____

Type of contact lenses: Soft Rigid Extended wear

How long do you wear your contact lenses each day? _____

Do you sleep in your contact lenses? Yes No If yes, how often/long? _____

How often do you replace your contact lenses? _____

What type of contact lens solution do you use? _____

Are your contact lenses comfortable? Yes No

Past/Present Ocular History Do you currently, or have you ever had any problems in the following areas?

	Yes	No	Unsure
Glaucoma (high eye pressures)	☐	☐	☐
Cataracts	☐	☐	☐
Macular Degeneration (ARMD)	☐	☐	☐
Retinal Disease	☐	☐	☐
Blindness	☐	☐	☐
Strabismus (Lazy or turned eye)	☐	☐	☐
Dry Eye	☐	☐	☐

Eye Surgery of any kind: _____

Other _____

Social History: This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer: Yes, I prefer to discuss with my doctor directly.

Do you drive? Yes No If yes, do you have difficulty with your eyes while driving? Yes No If yes, please explain: _____

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

Have you ever smoked? Yes No if yes, quit date: _____

Do you drink alcohol? Yes No if yes, type/amount/ how long: _____

Do you use recreational drugs? Yes No If yes, type/amount/ how long: _____

Have you ever been exposed to or infected with:

Gonorrhea Hepatitis HIV Syphilis No, I have not

Family History

Have any of your blood relatives, living or deceased, had any of these conditions?

Medical/Ocular Disease/Condition	Yes	No	Unsure	Relationship to You
Amblyopia	☐	☐	☐	_____
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Retinal Disorder	☐	☐	☐	_____
Strabismus (lazy or turned eye)	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Endocrine Disease	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
High Cholesterol	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____

Patient Financial Responsibility Agreement

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payments prior to any visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your doctor is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

In the event that your insurance is not valid or your coverage was terminated at the time of services rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered. In addition, if your insurance plan determines a service or procedure to be "not covered," you will be responsible for the complete charge of such services.

I agree to be responsible for the payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed. Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE (doctor's comments)

I have reviewed this history with the patient: _____

Doctor's Signature/Date

Notes:_____