LENTZ EYE CARE & ASSOCIATES

Medical History Questionnaire

Please complete this form to the best of your knowledge. The information you give will enable us to provide you with complete, quality eye health care.

GENERAL INFORMATION: Today's Date _____/_____/_____

Mr. Mrs. Miss Ms. Dr. Rev.

Patient Name _____

How do you wish to be addressed? (e.g. - Mr., 1st Name, Nickname) _____

Social Security # _____ Date of Birth _____/_____/_____ Sex M F

Home Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Number _____

E-Mail Address _____

Hobbies _____

If adult, your Occupation _____ Employer _____ Work # _____

Spouse's Name _____ Employer _____ Work # _____

If a minor, Parents' Names: Father _____

Employer _____ Work # _____

Mother _____

Employer _____ Work # _____

PLEASE LIST ANY MEMBERS OF YOUR HOUSEHOLD WHO COME TO OUR OFFICE:

_____

_____

I would like to discuss/learn more about: Glasses Sunglasses Contact Lenses Laser Refractive Surgery

Date of Last Eye Exam _____ Last Eye Doctor Seen _____

Reason for leaving previous office _____

Name of Medical Doctor _____

Doctor's Phone # _____ Date of Last Medical Exam _____

HOW DID YOU DECIDE TO COME TO OUR PRACTICE?

Referral (by whom)_____ Sign/Location_____

Newspaper_____ Yellow Pages_____ TV_____ Email_____ Website_____ Facebook_____

Employer_____ Insurance Website_____ Other_____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name _____ Relationship _____

Address _____ SS# _____ Birthdate: _____

_____ Work Phone _____

Insurance Company Name Home Phone _____

Policy Holder _____ I.D. # _____

***Please turn this form over and complete side two ***

MEDICAL HISTORY

Do you have any allergies to medications? ❑ No ❑ Yes If yes, please explain: _____

List any medications **you** take *(including all oral medications, eye medications and eye drops, oral contraceptives, aspirin, over the counter medications and home remedies):*

_____

_____

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

_____

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

_____

Are your pregnant and/or nursing? ❑ No ❑ Yes

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

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

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Disposable ❑ Other Are they comfortable? ❑ Yes ❑ No

FAMILY HISTORY

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

DISEASE/CONDITION	Self	Family	WHOM	DISEASE/CONDITION	Self	Family	WHOM
Blindness	❑	❑	_____	Diabetes	❑	❑	_____
Cataract	❑	❑	_____	Heart Disease	❑	❑	_____
Crossed Eyes	❑	❑	_____	High Blood Pressure	❑	❑	_____
Glaucoma	❑	❑	_____	Kidney Disease	❑	❑	_____
Macular Degeneration	❑	❑	_____	Lupus	❑	❑	_____
Retinal Detachment/Disease	❑	❑	_____	Thyroid Disease	❑	❑	_____
Arthritis	❑	❑	_____	Multiple Sclerosis	❑	❑	_____
Cancer	❑	❑	_____	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 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	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision / Halos	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy or Gritty Feeling	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excess Tearing / Watering	❑	❑	❑
Glare / Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes / Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE			
Thyroid / Other Glands	❑	❑	❑
EARS, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post-Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat / Mouth	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
VASCULAR / CARDIOVASCULAR			
Diabetes	❑	❑	❑
Heart Pain	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL			
Constipation	❑	❑	❑
Diarrhea	❑	❑	❑
GENITOURINARY			
Genitals / Kidney / Bladder	❑	❑	❑
BONES / JOINT / MUSCLES			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC / HEMATOLOGIC			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
ALLERGIC / IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

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

Dr's Sig. _____ Date _____ Patient's Sig. _____ Date _____

Dr's Sig. _____ Date _____ Patient's Sig. _____ Date _____

Dr's Sig. _____ Date _____ Patient's Sig. _____ Date _____