

MEDICAL HISTORY QUESTIONNAIRE (Please Print)

Name: _____ D.O.B.: _____
 Address: _____ Home Phone: _____
 City: _____ State: _____ Zip: _____ Cell Phone: _____
 Sex: (Circle one) Male/Female Height: _____ Weight: _____ Social Security: _____
 Primary Care Physician: _____ Primary Care Phone: _____
 Last Medical Exam: _____ Last Eye Exam: _____ Occupation: _____
 Reason for today's visit: _____

Medical History

Current Medications: _____
 Are you allergic to any medications? YES / NO If yes please list: _____
 Latex allergy? YES / NO
 Do you wear glasses? YES / NO Do you wear contacts? YES / NO Interested in Contacts? YES / NO
 Have you ever been treated for an eye injury or had eye surgery? YES/NO - If yes please list _____
 Please circle if **you** have/had any of the following: crossed eyes- lazy eye - drooping eyelid - prominent eye - glaucoma- retinal disease – cataracts

REVIEW OF SYSTEMS: DO YOU CURRENTLY, OR HAVE YOU EVER HAD ANY PROBLEMS IN THE FOLLOWING AREAS?

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
Eyes			Constitutional			Respiratory		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Fever, Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary			Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Neurological			Vascular/Cardiovascular		
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Itching/Burning	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine			Vascular	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	Ear/Nose/Throat/Mouth			Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Glare/ Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Bones/Joints/Muscles		
Chronic Lid/ Eye Infection	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Joint/Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashers/ Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/Hematologic		
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>			

SOCIAL HISTORY: This information is kept strictly confidential. However, you may discuss this portion with the Doctor if you prefer.

Do you drive? Yes / No - If yes, do you have visual difficulty when driving (explain)? YES / NO _____
 Do you use tobacco products? Yes / No - If yes, type/ amount/ how long: _____
 Do you drink alcohol? Yes / No - If yes, type/ amount/ how long: _____
 Do you use illegal drugs? Yes / No - If yes, type/ amount/ how long: _____
 Have you ever been exposed to or infected with: Gonorrhea Hepatitis A, B, C HIV Syphilis

Please read the following statements and sign below: 1. Pupil dilation may cause light sensitivity or other visual distortion for a short time following your exam. Sun shades are available at no charge. Please use caution when driving. 2. I have been explained the risks, benefits, and alternatives of polycarbonate lenses. 3. I understand that I am 100% liable for any charges that are not covered or denied by my insurance.

Patient Signature: X _____ **Date:** _____ **Doctor Signature:** _____

GIVEN NOTICE OF PRIVACY POLICIES (INITIAL HERE) x _____ **E-MAIL ADDRESS:** _____

OFFICE USE ONLY: History reviewed and updated.		
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FAMILY HISTORY: PLEASE NOTE ANY FAMILY HISTORY (parents, grandparents, siblings, children; living or deceased)

<u>DISEASE/CONDITION</u>	<u>NO</u>	<u>YES</u>	<u>RELATIONSHIP</u>	<u>DISEASE/CONDITION</u>	<u>NO</u>	<u>YES</u>	<u>RELATIONSHIP</u>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

REMINDERS AND NOTICES:

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call you to notify you that your eyeglasses and/or contact lenses are ready to be picked up, unless you tell us otherwise. We will mail you an appointment reminder on a post card and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

PATIENT'S INITIALS: X _____

Primary Vision Insurance

Name of Insurance: _____ ID # _____

Other Vision Insurance

Name of Insurance: _____ ID # _____

Primary Medical

Name of Insurance: _____ ID # _____ Group # _____

Secondary Medical

Name of Insurance: _____ ID # _____ Group # _____

Assignment of Benefits: I hereby assign all medical and/or vision benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to Bittel Vision Care. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I am financially responsible for the deductible, co-insurance, and non-covered services. Copays and non-covered services are to be paid at the time services are rendered. I have read and understand the payment policy of Bittel Vision Care.

Signed by Patient or Guarantor: _____ **Date:** _____