MEDICAL HISTORY QUESTIONNAIRE (Please Print) Today's Date: _____

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

Medical History

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

FAMILY HISTORY: PLEASE NOTE ANY FAMILY HISTORY (parents, grandparents, siblings, children; living or deceased)

DISEASE/CONDITION	NO	YES	RELATIONSHIP	DISEASE/CONDITION	NO	YES	RELATIONSHIP
Blindness	❑	❑	_____	Diabetes	❑	❑	_____
Cataract	❑	❑	_____	Heart Disease	❑	❑	_____
Crossed Eyes	❑	❑	_____	High Blood Pressure	❑	❑	_____
Glaucoma	❑	❑	_____	Kidney Disease	❑	❑	_____
Macular Degeneration	❑	❑	_____	Lupus	❑	❑	_____
Retinal Detachment	❑	❑	_____	Thyroid Disease	❑	❑	_____
Arthritis	❑	❑	_____	Cancer	❑	❑	_____
Retinal Disease	❑	❑	_____	Other_____	❑	❑	_____

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

Current Medications Prescription and Non- Prescription:

Pharmacy Name_____ Phone_____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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: X_____E-MAIL ADDRESS:_____

OFFICE USE ONLY: History reviewed and updated.							

OVER →

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	❑	❑	Fever, Weight loss/gain	❑	❑	Asthma	❑	❑
Blurred Vision	❑	❑	**Integumentary**			Chronic Bronchitis	❑	❑
Distorted Vision	❑	❑	Skin	❑	❑	Emphysema	❑	❑
Dryness	❑	❑	**Neurological**			**Vascular/Cardiovascular**		
Mucous Discharge	❑	❑	Headaches	❑	❑	Diabetes	❑	❑
Redness	❑	❑	Migraines	❑	❑	Heart Pain	❑	❑
Sandy or Gritty Feeling	❑	❑	Seizures	❑	❑	High Blood Pressure	❑	❑
Itching/Burning	❑	❑	**Endocrine**			Vascular	❑	❑
Foreign Body Sensation	❑	❑	Thyroid/Other Glands	❑	❑	**Gastrointestinal**		
Excess Tearing/Watering	❑	❑	**Ear/Nose/Throat/Mouth**			Diarrhea	❑	❑
Glare/ Light Sensitivity	❑	❑	Allergies/Hay Fever	❑	❑	Constipation	❑	❑
Eye Pain Soreness	❑	❑	Sinus Congestion	❑	❑	**Bones/Joints/Muscles**		
Chronic Lid/ Eye Infection	❑	❑	Runny Nose	❑	❑	Rheumatoid Arthritis	❑	❑
Styes or Chalazion	❑	❑	Post Nasal Drip	❑	❑	Joint/Muscle Pain	❑	❑
Flashers/ Floaters	❑	❑	Chronic Cough	❑	❑	**Lymphatic/Hematologic**		
Tired Eyes	❑	❑	Dry Throat/Mouth	❑	❑	Anemia	❑	❑
Psychiatric	❑	❑	**Genitourinary**			Bleeding Problems	❑	❑
Allergic/Immunologic	❑	❑	Genitals/Kidney/Bladder	❑	❑			

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 INTIALS: X_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I do hereby authorize Dr. Robert P. Bittel Jr., Optometrist to release my information to the following persons:

Name: _____ Phone: _____

Relationship to Patient: _____

Name: _____ Phone: _____

Relationship to Patient: _____

Patient Signature: X_____ Date: _____

Dr. Robert P BIttel Jr., Optometrist

5301 Grove Road, Ste. B530
Pittsburgh, PA 15236
(412)884-2020

716 Coal Valley Road
Jefferson Hills, Pa 15236
(412)384-8007