



established 1953

# Medical Questionnaire

TODAY'S DATE: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent Name (if child): \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured Social Security number: \_\_\_\_\_

Patient Relationship to Insured (circle one): Self Spouse Child Other

Primary Insurance Company

Secondary Insurance Company

Company: \_\_\_\_\_

Company: \_\_\_\_\_

Policy #: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Group#: \_\_\_\_\_

Medicare patients, is Medicare your primary insurance carrier? (circle one) Yes No

Primary Care Physician: \_\_\_\_\_ Last Physical: \_\_\_\_\_

Do you have or had problems with the following; **if yes, please specify:**

1. Weight loss/gain?  Yes  No \_\_\_\_\_

2. Ears, Nose, Mouth, Throat, Sinus?  Yes  No \_\_\_\_\_

3. Cardiovascular? (TIA, Stroke, Circulation)  Yes  No \_\_\_\_\_

4. Respiratory?  Yes  No \_\_\_\_\_

5. Gastrointestinal?  Yes  No \_\_\_\_\_

6. Genitourinary?  Yes  No \_\_\_\_\_

7. Musculoskeletal? (Arthritis, muscle/joint pain... )  Yes  No \_\_\_\_\_

8. Skin and or breast?  Yes  No \_\_\_\_\_

9. Neurological?  Yes  No \_\_\_\_\_

10. Psychiatric?  Yes  No \_\_\_\_\_

**PLEASE TURN THIS FORM OVER AND COMPLETE THE BACK**



11. Endocrine? (Diabetes, thyroid, hormone,...)  Yes  No \_\_\_\_\_

12. Hematological (blood)/ lymphatic?  Yes  No \_\_\_\_\_

13. Allergic/immunologic?  Yes  No \_\_\_\_\_

14. Eyes?  Yes  No \_\_\_\_\_

(ARMD, Glaucoma, Diabetic retinopathy, LASIX, Sensitivity to lights, Dry eye, Blurred/Decreased Vision, Trouble reading, difficulty driving or seeing the blackboard, Trouble with night vision,...)

Please list any medications/pills you take: (include vitamins, aspirin, herbal supplements) \_\_\_\_\_

Please list any allergies to medications: \_\_\_\_\_

Please list any major surgeries, injuries or serious illnesses: \_\_\_\_\_

Do/ Did you use tobacco?  Yes  No If yes, how many per day? \_\_\_\_\_

Do/ Did you use alcohol?  Yes  No If yes, how many glasses per day? \_\_\_\_\_

Do you drive?  Yes  No If yes, do you experience problems with night driving? \_\_\_\_\_

Please list any avocations or hobbies: \_\_\_\_\_

How long ago was your last eye exam? \_\_\_\_\_ How old are your glasses? \_\_\_\_\_

Do you wear contact lenses?  Yes  No If no, are you interested in being fit with contact lenses today?  Yes  No

If yes, are they soft contact lenses?  Or hard contact lenses?  Are the disposable contact lenses?  Yes  No

How old is the pair of contact lenses you are wearing today?

What cleaning solutions do you use?

Are you interested in LASIK surgery or learning more about this procedure?  Yes  No

### FAMILY HISTORY

Is there family history of; **if yes, please specify:**

1. Cardiovascular disease?  Yes  No \_\_\_\_\_

2. Respiratory problems? (Asthma, emphysema, COPD,...)  Yes  No \_\_\_\_\_

3. Cancer?  Yes  No \_\_\_\_\_

4. Endocrine problems? (Diabetes, Thyroid,...)  Yes  No \_\_\_\_\_

5. Eye problems?  Yes  No \_\_\_\_\_

6. Other? \_\_\_\_\_

How did you learn about our office?  My insurance company  Yellow Pages  Advertisement

Driving by  Referral—if so, who: \_\_\_\_\_

Do you participate in a medical savings plan/cafeteria plan?  Yes  No