Medical History Questionnaire

Today's Date: _____/_____/_____ **Preferred Language:** _____ **Ethnicity:** _____

Preferred Method of Communication: Email / Postal / Phone / Text **Race:** _____

Name: _____ **Male / Female**

Address:_____**Phone:** _____

City/State: _____**Zip**_____**Work Phone:** _____

E-Mail Address: _____

Birth Date: _____/_____/_____ **Social Security #:** ___-___-_____ **Cell Phone:** _____

If child, Father's Name: _____ **Phone:** _____ **Mother's Name:** _____ **Phone:** _____

Father's Address: _____ **Mother's Address:** _____

City/State: _____**Zip**_____ **City/State:** _____**Zip**_____

Place of employment (if child, both parents' employers):

Self_____

Father_____

Mother_____

Name of spouse _____**Emergency Contact**_____

Emergency contact phone #_____

Vision Insurance Information

Vision Insurance Company: _____

Policy Holder's Employer: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____

Policy Group/Contract #: _____

Policy Holder's Date of Birth: _____/_____/_____

Medical Insurance Information

Medical Ins Co.: _____

Policy Holder's Employer: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____

Policy Group/Contract#: _____

Policy Holder's Date of Birth: _____/_____/_____

⇒ I authorize treatment of the above named person and agree to promptly pay all fees for such treatment or goods unless other credit arrangements are agreed upon in writing. I hereby authorize release of records needed for insurance payment and authorize payment directly to Zeeland Vision Services.

Name: _____**Signature:**_____Date_____

Medical History

Name of Medical Doctor_____ Last Medical Exam___/_____/_____

List any allergies to medications: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications): _____

_____

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

_____

Are you pregnant and/or nursing? ☐ No ☐ yes

CONTINUED ON BACK

Eye Health History

Do you wear glasses? ☐ No ☐ yes
Do you wear contact lenses? ☐ No ☐ yes Gas Permeable/Hard or Soft Disposable (circle one)

Circle any of the following that you have had:

BLINDNESS **CROSSED EYES** **CATARACT** **GLAUCOMA** **MACULAR DEGENERATION**

RETINAL DETACHMENT/DISEASE **OTHER, please list**_____

Family Health History (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Diabetes	☐	☐	_____
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)

Have you ever used tobacco products? (circle)

NEVER SMOKED **FORMER SMOKER** **CURRENT/EVERYDAY SMOKER**

Do you drink alcohol? Circle the most applicable below.

NONE **SOCIAL USE ONLY** **1+ DRINKS DAILY**

Do you use illegal drugs? ☐ No ☐ yes

Do you have any sexually transmitted diseases? ☐ No ☐ yes

Have you ever had a blood transfusion? ☐ No ☐ yes

Review of Systems

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

Allergic/Immunologic
- Lupus (SLE)
- Rheumatoid Arthritis
- Environmental Allergies
- Season Allergies

Cardiovascular
- High Blood Pressure
- Heart Disease
- Stroke
- Vascular Disease
- High Cholesterol

General Health
- Weight loss/gain
- Fever
- Fatigue
- Trauma

Endocrine/Glands
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction

Gastrointestinal
- Crohn's Disease
- Colitis
- Acid Reflux/Ulcer

Genital/Urinary
- Urinary Tract Infection
- HIV Positive
- Herpes/Chlamydia

Ear, Nose, and Throat
- Sinusitis
- Upper Respiratory Tract Infection

Hematologic/Lymphatic
- Anemia
- Leukemia
- Bleeding Disorder

Skin/Integumentary
- Eczema
- Rosacea
- Psoriasis

Muscle/Skeletal
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis

Neurological
- Multiple Sclerosis
- Epilepsy
- Tremors

Psychiatric
- Depression
- Bi-Polar
- Schizophrenia

Respiratory
- Asthma
- Bronchitis
- Emphysema