Eyecare Associates
OF COLUMBUS

Medical History Questionnaire

Name: _____ Birth Date: _____ Today's Date: _____

PATIENT MEDICAL HISTORY

Name of Medical Doctor: _____ Town: _____ Date of Last Medical Exam: _____

Current Medications: (Prescription or Over the Counter) Please list the name of the medications including eye drops, vitamins and oral contraceptives: _____

_____

_____

Do you have allergies to medications? ☐ No ☐ Yes If so, what medications? _____

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

_____

Are you pregnant? ☐ No ☐ Yes Due Date (if known) _____ Are you nursing? ☐ No ☐ Yes

Date of Last Eye Exam: _____ By Whom? _____

Do you wear glasses? ☐ No ☐ Yes How old are your glasses? _____ Do you have a back up pair? ☐ No ☐ Yes

Do you currently wear contacts? ☐ No ☐ Yes What kind? _____ Solutions used? _____

How often do you replace your contacts? _____

FAMILY HISTORY

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

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
Macular Degeneration	☐	☐	_____
Eye Injury	☐	☐	_____
Retinal Disease	☐	☐	_____
Other Disease	☐	☐	_____
Blindness	☐	☐	_____
Crossed eyes	☐	☐	_____
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
Heart Disease	☐	☐	_____
Hypertension	☐	☐	_____
Cholesterol	☐	☐	_____
Kidney Disease	☐	☐	_____
Stroke	☐	☐	_____

SOCIAL HISTORY

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

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

REVIEW OF SYSTEMS

Have you ever been diagnosed or treated for the following health problems?

EYES

			(explain/medications)
Loss of Vision	☐ No	☐ Yes	
Blurred Vision	☐ No	☐ Yes	
Distorted Vision / Halos	☐ No	☐ Yes	
Loss of Side Vision	☐ No	☐ Yes	
Double Vision	☐ No	☐ Yes	
Dryness	☐ No	☐ Yes	
Eye Infections	☐ No	☐ Yes	
Redness	☐ No	☐ Yes	
Sandy Gritty Feeling	☐ No	☐ Yes	
Itching	☐ No	☐ Yes	
Burning	☐ No	☐ Yes	
Excess Tearing / Watering	☐ No	☐ Yes	
Glare / Light Sensitivity	☐ No	☐ Yes	
Eye Pain or Soreness	☐ No	☐ Yes	
Chronic Infection of Eye or Lid	☐ No	☐ Yes	
Stye or Chalazion	☐ No	☐ Yes	
Flashes of Lights	☐ No	☐ Yes	
Floaters in Vision	☐ No	☐ Yes	
Tired Eyes	☐ No	☐ Yes	
Cataracts	☐ No	☐ Yes	
Crossed Eye / Turned Eye	☐ No	☐ Yes	
Glaucoma	☐ No	☐ Yes	
Macular Degeneration	☐ No	☐ Yes	
Retinal Detachment	☐ No	☐ Yes	
Corneal Abrasions	☐ No	☐ Yes	
Eye Injury	☐ No	☐ Yes	
Iritis / Uveitis	☐ No	☐ Yes	
Lazy Eye	☐ No	☐ Yes	

BONES / JOINTS / MUSCLES

Rheumatoid Arthritis	☐ No	☐ Yes	
Muscle Pain	☐ No	☐ Yes	
Joint Pain	☐ No	☐ Yes	

PSYCHIATRIC

Memory Loss	☐ No	☐ Yes	
Depression	☐ No	☐ Yes	
Panic Attack / Anxious Tendencies	☐ No	☐ Yes	

CONSTITUTIONAL

			(explain/medications)
Fever, Weight Loss / Gain	☐ No	☐ Yes	
Chronic Fatigue	☐ No	☐ Yes	

INTEGUMENTARY (Skin)

Eczema / Rashes / Moles	☐ No	☐ Yes	

NEUROLOGICAL

Headaches	☐ No	☐ Yes	
Migraines	☐ No	☐ Yes	
Seizures / Fainting	☐ No	☐ Yes	

ENDOCRINE

Diabetes	☐ No	☐ Yes	
Thyroid / Other Glands	☐ No	☐ Yes	
Intolerance to Heat or Cold	☐ No	☐ Yes	

EARS, NOSE, MOUTH, THROAT

Hearing Loss	☐ No	☐ Yes	
Allergies / Hay Fever	☐ No	☐ Yes	
Chronic Cough	☐ No	☐ Yes	
Dry Throat / Mouth	☐ No	☐ Yes	

RESPIRATORY

Asthma / Emphysema	☐ No	☐ Yes	
Chronic Bronchitis	☐ No	☐ Yes	

CARDIOVASCULAR / VASCULAR

High Blood Pressure	☐ No	☐ Yes	
Heart / Chest Pain	☐ No	☐ Yes	
Vascular Disease	☐ No	☐ Yes	
High Cholesterol	☐ No	☐ Yes	

GASTROINTESTINAL

Diarrhea / Constipation	☐ No	☐ Yes	
Abdominal Pain / Ulcers	☐ No	☐ Yes	
Nausea / Vomiting	☐ No	☐ Yes	

GENITOURINARY

Genitals / Kidney / Bladder	☐ No	☐ Yes	

LYMPHATIC / HEMATOLOGIC

Anemia	☐ No	☐ Yes	
Bleeding Problems	☐ No	☐ Yes	
Bruising	☐ No	☐ Yes	

ALLERGIC / IMMUNOLOGIC ☐ No ☐ Yes

OPTOMAP IF THE RECEPTIONIST HAS NOT GIVEN YOU THE INFORMATION ON THE OPTOMAP RETINAL EXAMINATION, PLEASE ASK. IT IS A NEW, INNOVATIVE PROCEDURE THAT IS HIGHLY RECOMMENDED BY YOUR OPTOMETRIST. DO YOU WISH TO INCLUDE THE OPTOMAP IN YOUR EXAM? ☐ ACCEPT ☐ DECLINE

ASSIGNMENT AND RELEASE

I acknowledge that I received a copy of Eyecare Associates of Columbus, P.C. Notice of Privacy Practices. I authorize the release of any medical information necessary to process all claims. I also authorize the release of payment of medical benefits to my physician and understand I am responsible for non-covered services. For your protection, Nebraska law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claims for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Our office policy is that if your account has a credit balance of under $10.00 it will remain in your account to be used as a credit for future visits.

Patients Signature _____ Date _____