North Country Vision Center-Medical History Questionnaire

Today's Date:___/___/____

Name: ______________________________________		Gender: ☐M ☐F	Marital Status: ☐Single ☐ Married ☐Other
Address: ____________________________________		☐ Employed ☐ Retired ☐ Student ☐ Unemployed ☐ Other
City: ________________________	Zip: _________	Guardian name(if under 18):_____________________________________
Phone(H): _____________	(W/C): ___________	Last Medical Exam: ____ / ____ / _____
Date of Birth: ____ / ____ / _____		Name of Medical Doctor: ____
Email Address: _____________________________________		Last Eye Exam: ____ / ____ / _____

Insurance: Please fill out completely

Insurance Name: ____________________________________ ID Number: ___________________________________

Insured's Name: _____________________________________ Group Number: ________________________________

Date of Birth: ____ / ____/ ____ ☐Self ☐Spouse ☐Child Employer: ____________________________________

Insured Work Phone: ___________________________________ Occupation:____________________

MEDICAL HISTORY: Do you have or have you ever had, any problems in the following areas: (check all that apply)

ALLERGIC/ IMMUNOLOGIC: ☐Allergy / Hay Fever

ENDOCRINE:☐Diabetes☐Chronic Fatigue☐Thyroid Disease

BONES/JOINTS/MUSCLES: ☐Joint Pain☐Muscle Pain☐Rheumatoid Arthritis

INTEGUMENTARY (Skin):☐Cancer☐Easy Bruising☐Rashes

LYMPHATIC/HEMATOLOGIC: ☐Anemia☐Bleeding Problems☐Breast Cancer

NEUROLOGICAL:☐Headaches☐Migraines☐Seizures☐Stroke

CARDIOVASCULAR/VASCULAR: ☐Diabetes☐Heart Disease☐High Blood Pressure☐High Cholesterol

EARS, NOSE, MOUTH, THROAT: ☐Dry Throat/Mouth☐Chronic Cough☐Post Nasal Drip☐Runny Nose☐Sinus Congestion

EYES: ☐Blurred Vision☐Loss of Vision☐Distorted Vision☐Double Vision☐Dryness☐Sandy or Gritty Feeling☐Foreign Body Sensation
☐Eye Pain or Soreness☐Mucous Discharge☐Redness☐ Tired Eyes☐Itching☐Excess Tearing/Watering☐Styes or Chalazion
☐Burning☐Chronic Infection of Eye or Lid☐Glare/Light Sensitivity☐Flashes/Floaters in Vision

Do you have any allergies to medications? ☐No ☐Yes If yes, explain:
____
____

List any medications you take (Including oral contraceptives, aspirin, over the counter medications and home remedies):____________________________
____

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

Are you pregnant and/or nursing? ☐No ☐Yes Do you wear glasses? ☐No ☐Yes If yes, how old are your glasses?_________

Check any of the following that you have had and explain: ____
☐Crossed Eye ☐Drooping Eyelid ☐Eye Injury ☐Lazy Eye ☐Retinal Disease ☐Cataract ☐Eye Infection ☐Glaucoma ☐Prominent Eyes

CONTACT LENS HISTORY

Do you wear contact lenses? ☐No ☐Yes If yes, how old are your contacts?________________ Brand: _____________________

What type of contact lenses do you wear?☐Rigid ☐Soft ☐Toric ☐Extended Wear

How many Hours/Day do you wear your contact lenses? ___________ Do you sleep in your contacts? ☐Yes ☐No If yes, How many nights per week? ______

How often do you replace your contacts? ☐Daily ☐1-2 Weeks ☐1 Month ☐More than 1 Month

Do you experience…? ☐Dryness ☐Redness ☐Itching ☐Burning ☐Discomfort ☐Poor Vision

SOCIAL HISTORY -*This information is kept strictly confidential. However, you may discuss this portion directly with your doctor, if you prefer.* ☐**Yes, I would prefer to discuss my Social History information directly with my doctor**

Have you ever been exposed to or infected with: ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis

Do you drive? ☐No ☐Yes If yes, do you have visual difficulty when driving? ☐No ☐Yes

-If you have difficulty when driving, please describe ____

FAMILY HISTORY -Please note any family history (parent, grandparents, siblings, children, living or deceased) for the following conditions:

Disease/Condition	No	Yes	Relationship To You	Disease/Condition	No	Yes	Relationship To You
Blindness	☐	☐	___________________________	Cancer	☐	☐	___________________________
Cataract	☐	☐	___________________________	Diabetes	☐	☐	___________________________
Crossed Eyes	☐	☐	___________________________	Heart Disease	☐	☐	___________________________
Glaucoma	☐	☐	___________________________	High Blood Pressure	☐	☐	___________________________
Macular Degeneration	☐	☐	___________________________	Lupus	☐	☐	___________________________
Retinal Detachment/Disease	☐	☐	___________________________	Thyroid Disease	☐	☐	___________________________

Hippa Notice and Authorized Signature

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment for benefits/services rendered to North Country Vision Center. I understand that I am responsible for fees that are not paid by my insurance company. Signature:____ Date:_______________________

Patient's Signature: ____________________________________ Date: __________________

Reviewed By: ____ Date: __________________