Medical History Questionnaire

Today's Date / /

Name: _____ Home Phone: _____

Mailing Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Birth Date: / / Social Security #: _____ Last Eye Exam: / /

Guardian (If Applicable) _____ Location: _____

Occupation: _____ E-mail Address: _____

Were you referred to our office? YES NO If yes, Who may we thank for referring you? _____

If no, How did you hear about our Office: (circle one) Internet Phone Book Sign Postcard Facebook Radio Other

Name of :

Medical Doctor: _____ Pharmacy: _____

Medical Insurance _____ Vision Insurance _____

Primary Card Holders Name _____ Date of Birth / /

Social Security #: _____

Review of Systems

(Please Circle any problems you have with the following:)

CONSTITUTIONAL: Developmental Disabilities, Cancer, Fatigue Syndrome

ENT: Hearing Loss, Sinusitis, Dry Mouth, Laryngitis

INTEGUMENTARY: Eczema, Rosacea, Shingles

NEUROLOGICAL: Headaches, Migraine, Multiple Sclerosis, Epilepsy/Seizures, Cerebral Palsy, Tumor, Stroke/CVA, Autism

RESPIRATORY: Asthma, Chronic Bronchitis, Emphysema, Sleep Apnea

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

VASCULAR/CARDIOVASCULAR: Heart Disease, High Blood Pressure, Stroke, Vascular Disease Congesive Heart Failure

GASTROINTESTIONAL: Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease

GENITOURINARY: Prostate disease/cancer, Kidney disease, Bladder, STD - herpes/chlamydia, Other

BONES/JOINTS/MUSCLES: Rheumatoid Arthritis, Muscle Pain, Joint Pain, Fibromyalgia, Gout

HEMOTOLOGIC/LYMPHATIC: Anemia, Ulcer, High Cholesterol, HIV/AIDS

ENDOCRINE: Thyroid, Diabetes Type 1, Diabetes Type 2, Hormonal Dysfunction

ALLERGIC/IMMUNOLOGIC: Drug Allergies, Environmental Allergies, Rheumatoid Arthritis, Sjogren's Syndrome, Lupus

PSYCHIATRIC: Depession, Attention Deficit (ADD/ADHD), Anxiety Disorder, Bipolar

If you checked any of the above or have a condition not listed, please explain

_____

_____

Medical History

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

Are you allergic to any medications? YES NO

If yes explain: _____

Are you allergic to Latex? YES NO

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

Are you pregnant YES NO and/or nursing? YES NO

Eye History

Circle any of the following that you have had: Crossed eyes Lazy eye Drooping eyelid Eye injury

Glaucoma Retinal Disease Cataracts Eye infections

Do you wear glasses? YES NO If yes, how old is your pair of lenses? _____

Do you wear contact lenses? YES NO If yes, how old is your pair of lenses? _____

Type of Contact lenses: Rigid Soft Extended Wear Other Are they comfortable _____

Social History

Do you use tobacco prducts? YES NO If yes, Type/Amount/How Long? _____

Do you use alcohol? YES NO

Do you drive YES NO If yes, do you have visual diffculty when driving YES NO

If yes, please describe: _____

Family History (If Yes for the following disease/condition, please circle relationship(s))

Disease/Condition	Relationship to you					
Blindnes	Father	Mother	Brother	Sister	Daughter	Son
Cataract	Father	Mother	Brother	Sister	Daughter	Son
Glaucoma	Father	Mother	Brother	Sister	Daughter	Son
Macular Degeneration	Father	Mother	Brother	Sister	Daughter	Son
Cancer	Father	Mother	Brother	Sister	Daughter	Son
Diabetes	Father	Mother	Brother	Sister	Daughter	Son
High Blood Pressure	Father	Mother	Brother	Sister	Daughter	Son
Thyroid Disease	Father	Mother	Brother	Sister	Daughter	Son
Other _____	Father	Mother	Brother	Sister	Daughter	Son

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Lexington Eye Care Clinic make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ **I have read or had explained to me Lexington Eye Care Clinic's Notice of Privacy Practice and agree to continue my care with Lexington Eye Care Clinic under said terms.**
- ☐ I was given the opportunity to read Lexington Eye Care Clinic's Notice of Privacy Practices and declined but wish to continue my care with Lexington Eye Care Clinic under the terms of LECC's privacy policies.
- ☐ I have read or had explained to me Lexington Eye Care Clinic's Notice of Privacy Practice and do not wish to continue my care with Lexington Eye Care Clinic under said terms.
- ☐ Knowing that standard email and text communication may not be totally secure, I still consent to communications from my doctor or staff through my standard email and texting decives.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

_____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient