VISION SOURCE® OF TEXARKANA

MEDICAL HISTORY QUESTIONNAIRE

TODAY'S DATE: _____/ _____/_____ LAST EYE EXAM: _____/ _____/_____

PATIENT NAME		SOC SEC. #	BIRTHDATE	INSURANCE MEDICAL GROUP & NO.	
ADDRESS		CITY		STATE	ZIP
HOME PHONE (OR PARENT IF MINOR)	BUSINESS PHONE	OCCUPATION		EMPLOYER	
NAME OF PARENT OR SPOUSE (please circle)		GRADE IF STUDENT	DO YOU USE A COMPUTER SCREEN? □ NO □ YES; HOW MUCH		
METHOD OF PAYMENT □ MEDICARE □ MEDICAID □ CHECK □ CASH □ CREDIT CARD		GUARANTOR	HAVE WE SEEN OTHER MEMBERS OF YOUR FAMILY? □ NO □ YES IF YES, WHOM		
MEDICAL DOCTOR'S NAME	DR.'S PHONE	REFERRED BY	DATE OF LAST MEDICAL EXAM		

Medical History

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 any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injury: _____

Are you pregnant and/or nursing? □ no □ yes
Do you wear glasses? □ no □ yes If yes, how old is your current pair of lenses? _____
Do you wear contact lenses? □ no □ yes If yes, how old is your current pair of lenses? _____
Type of contact lenses: □ rigid □ soft □ extended wear □ Other Are they comfortable? □ no □ yes

Family History

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

DISEASE / CONDIDTION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	□	□	□	_____
Cataract	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment / Disease	□	□	□	_____
Arthritis	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Kidney Disease	□	□	□	_____
Lupus	□	□	□	_____
Thyroid Disease	□	□	□	_____
Other _____	□	□	□	_____

• Please turn this form over and complete side two•

Medical History This info mation is kepr t strictly con iden ial. t 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)

Do you drive? □ no □ yes If yes, do you have visual difficulty when driving? □ no □ yes If yes, 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? □ no □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

Review of Systems

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

System	No	Yes	?		No	Yes	?
CONSTITUTIONAL				EAR, NOSE, MOUTH, THROAT			
Fever, Weight Loss / Gain				Allergies / Hay Fever			
INTEGUMENTARY				Sinus Congestion			
Skin				Runny Nose			
NEUROLOGICAL				Post-Nasal Drip			
Headaches				Chronic Cough			
Migraines				Dry Throat / Mouth			
Seizures				RESPIRATORY			
EYES				Asthma			
Loss of Vision				Chronic Bronchitis			
Blurred Vision				Emphysema			
Distorted Vision / Halos				VASCULAR / CARDIOVASCULAR			
Loss of Side Vision				Diabetes			
Double Vision				Heart Pain			
Dryness				High Blood Pressure			
Mucous Discharge				Vascular Disease			
Redness				GASTROINTESTINAL			
Sandy or Gritty Feelings				Diarrhea			
Itching				Constipation			
Burning				GENITOURINARY			
Foreign Body Sensation				Genitals / Kidney / Bladder			
Excess Tearing / Watering				BONES / JOINTS / MUSCLES			
Glare / Light Sensitivity				Rheumatoid Arthritis			
Eye Pain or Soreness				Muscle Pain			
Chronic Infection of Eye or Li				Joint Pain			
Sties or Chalazion				LYMPHATIC / HEMATOLOGIC			
Flashes / Floaters in Vision				Anemia			
Tired Eyes				Bleeding Problems			
ENDOCRINE				ALLERGIC / IMMUNOLOGIC			
Thyroid / Other Glands				PSYCHIATRIC			

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____

_____ _____

Doctor's Signature Date