Medical History Questionnaire

We understand how much people dislike filling out forms, but this one must be completed if you want us to submit the fees for the examination to your insurance company. ***The insurance companies require us to collect this information or they will refuse to pay for your tests.*** Our new procedure will mean that you only have to fill this out once, and we can simply review it with you in the future. Please know that this information is strictly confidential & will not be released to anyone without your prior, written authorization, with the possible exception of clinically important letters to any other doctors you see. If you prefer that we not send this information to anyone, including your other doctors, please let us know.

If you would rather not fill out this form, meaning you prefer to pay for the testing yourself and possibly take it up with your insurance company on your own, please sign here and let the tech know.

I would prefer to pay directly for services and materials now, and submit any insurance claims myself.
Signature of patient (or responsible party):_____Date:_____

Name:_____ Date of Birth:____ / ____ / ____ Today's Date :____ / ____ / ____
Address:_____ City:_____State:_____Zip:_____
Home phone:_____ Cell phone:_____ E-mail:_____
Social Security #:_____-____-_____
Occupation:_____ Employer:_____ Work phone:_____
Emerg. contact - name:_____ Phone #:_____
Please circle preferred method of contact: home phone cell phone text e-mail other:

Family Medical History (Grandparents, Parents, Siblings or Children)	
Condition	Relationship to you: (Mother, Father, etc.)
Glaucoma	
Cataracts	
Eye problem - other:	
Diabetes	
Heart/high blood pressure	
Thyroid	
Stroke	
Other:	

Name of **medical** doctor:_____MD/DO City, State:_____
Last **medical exam**_____ / _____ / _____

Do you have any known **allergies to medications**: no☐ yes☐ If yes, please explain: _____
_____

Current medications:	dosage	approx date started:	for what condition:

Patient Medical History/Review of systems			
Do you now have, or have you ever had problems in the following areas:			
General medical systems:	No	Yes	Date diagnosed, explanation:
Fever, Weight loss/gain			
Skin problems			
Headaches or migraines			
Seizures or other neuro			
Thyroid, other glands			
Allergies, Hay Fever			
Sinus congestion			
Chronic cough			
Dry throat/mouth			
Asthma, bronchitis, emphysema			
Diabetes			
Heart problems			
High blood pressure			
Vascular disease			
High cholesterol			
GI (unusual diarrhea/constipation, etc)			
Kidneys/bladder			
Arthritis - Rheumatoid or other			
Anemia, hemophilia, other			
Is there anything else the doctor should know about?:			
Women: Are you pregnant (and/or nursing?) Yes ☐ No ☐ Maybe ☐			

Please list all major **injuries, surgeries and/or hospitalizations**:

Approx. date	Brief description of procedure

Social History
Do you drive? ☐ yes ☐ no If yes, do you have trouble seeing when you drive? ☐ yes ☐ no
Do you use tobacco? ☐ yes ☐ no If yes, type/amount/how long?:
Do you drink alcohol? ☐ yes ☐ no If yes, type/amount/how long?:
Do you use illegal drugs? ☐ yes ☐ no If yes, type/amount/how long?:
Have you ever been exposed to/infected with: ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ Gonorrhea

Pt. Signature:_____ Dr. Signature:_____