



Norfolk
 220 W. Brambleton Ave. Ste. 111
 Norfolk, Virginia 23510
 (757) 622-0200

Virginia Beach
 1547 Laskin Road
 VB, Virginia 23451
 (757) 425-0200

MEDICAL HISTORY QUESTIONNAIRE

PATIENT'S NAME (FIRST, MIDDLE, LAST)		DATE
ADDRESS		EMAIL
CITY	STATE	ZIP
PHONE NUMBER: HOME	WORK	CELL
BEST TIME TO CALL?	DATE OF BIRTH	AGE
SPOUSE/GUARDIAN NAME		SOCIAL SECURITY #
PATIENT'S OCCUPATION		RELATIONSHIP
EMPLOYER		
PREVIOUS EYE DOCTOR	LAST EXAM DATE	
HOW DID YOU HEAR ABOUT GILBERT EYECARE?		
REASON FOR TODAY'S VISIT:		
HOW LONG HAS THIS BEEN BOTHERING YOU?		
ARE YOU PREGNANT OR NURSING? <input type="checkbox"/> Yes <input type="checkbox"/> No		

ALLERGIES			MEDICATIONS				
<u>MEDS</u>	<u>YES - NO</u>	<u>YEAR IT STARTED</u>	<u>NAME OF MED</u>	<u>START DATE</u>	<u>DOSE</u>	<u>FREQUENCY</u>	<u>INDICTION</u>
SULFA	YES - NO		EG. METOPROL	2/26/01	25 MG	1x DAY	HIGH BP
PENICILLIN	YES - NO						
ASPIRIN	YES - NO						
PAIN MED	YES - NO						
OTHER	YES - NO						
EYE DROPS	YES - NO						
SEASONAL	YES - NO						

PLEASE LIST ALL MAJOR SURGERIES AND/OR HOSPITALIZATION YOU HAVE HAD: _____

DO YOU WEAR EYEGLASSES? YES NO IF YES, HOW OLD IS YOUR CURRENT PAIR OF GLASSES? _____

DO YOU WEAR CONTACT LENSES? YES NO IF YES, HOW OLD IS YOUR CURRENT PAIR OF LENSES? _____

TYPE OF CONTACT LENSES? RIGID SOFT EXTENDED WEAR ARE THEY COMFORTABLE YES NO

IF YOU ARE NOT CURRENTLY A CONTACT LENS WEARER, ARE YOU INTERESTED IN CONTACTS? YES NO

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PATIENT'S MEDICAL HISTORY		PATIENT'S OCULAR HISTORY	
<u>SELF</u>	<u>FAMILY</u>	<u>SELF</u>	<u>FAMILY</u>
_____ HIGH BLOOD PRESSURE _____ YEARS	_____	_____ CATARACTS	_____
_____ HEART DISEASE	_____	_____ GLAUCOMA	_____
_____ DIABETES _____ YEARS	_____	_____ MACULAR DEGENERATION	_____
_____ CANCER	_____	_____ STRABISMUS/EYE TURN	_____
_____ ARTHRITIS	_____	_____ AMBLYOPIA/LAZY EYE	_____
_____ RESPIRATORY DISEASE	_____	_____ RETINAL DISORDERS	_____
_____ ASTHMA	_____	_____ EYE INJURIES	_____
_____ STROKE	_____	_____ EYE SURGERY	_____
_____ MULTIPLE SCLEROSIS	_____	IF YES OR IF YOU HAVE ANY CONDITION THAT IS NOT LISTED ABOVE, PLEASE EXPLAIN _____	
_____ HEADACHES # _____ PER MO	_____	_____	_____
_____ SICKLE CELL ANEMIA	_____	_____	_____
_____ CROHNS DISEASE	_____	_____	_____

SOCIAL HISTORY THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL. HOWEVER, YOU MAY DISCUSS THIS PORTION DIRECTLY WITH THE DOCTOR IF YOU PREFER

Yes, I would prefer to discuss my social history directly with the doctor

DO YOU DRIVE? Yes No

IF YES, DO YOU HAVE VISUAL DIFFICULTY WHEN DRIVING? Yes No IF YES, TYPE/AMOUNT/HOW LONG? _____

DO YOU USE TOBACCO PRODUCTS? 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 OR INFECTED WITH HIV, HEPATITIS OR SYPHILIS (PLEASE CIRCLE)

REVIEW OF SYSTEMS DO YOU CURRENTLY, OR HAVE EVER HAD ANY OF THE PROBLEMS IN THE FOLLOWING AREAS:

CONSTITUTIONAL - FEVER, NIGHT SWEATS, FATIGUE, WEIGHT LOSS/GAIN

CARDIOVASCULAR - ANGINA, BLOOD CLOTS, HEART ATTACK, HEART FAILURE, HEART MURMUR, RHEUMATIC FEVER

EARS, NOSE, THROAT - CHRONIC SINUS PROBLEMS

ENDOCRINE - MENOPAUSE, PITUITARY DISEASE

GASTROINTESTINAL - COLITIS, CHRONIC DIARRHEA, HIATAL HERNIA, ACID REFLUX, ULCER

GENITOURINARY - BLADDER INFECTIONS, KIDNEY DISEASE, VENEREAL DISEASE (HERPES, SYPHILIS, GONORRHEA, CHLAMYDIA)

HEMATOLOGICAL/LYMPHATIC - HEMOPHILIA, HEPATITIS, HIGH CHOLESTEROL, PAST BLOOD TRANSFUSIONS, SICKLE CELL ANEMIA OR TRAIT

IMMUNOLOGIC - AIDS/HIV, SARCOIDOSIS, SYSTEMIC LUPUS ERYTHEMATOSUS

MUSCULOSKELETAL - ARTHRITIS, SPINAL INJURY

NEUROLOGICAL - BRAIN ANEURYSM, EPILEPSY, MIGRAINE, SEIZURES, STROKE

PSYCHIATRIC - ANXIETY, ADD, ADHD, AUTISM, BIPOLAR DISORDER, DEPRESSION, PANIC DISORDER

RESPIRATORY - ASTHMA, EMPHYSEMA, LUNG CANCER, LUNG INFECTION, PNEUMONIA, TUBERCULOSIS

SKIN/BREAST - ACNE, ACNE ROSACIA, BREAST CANCER, SEBORRHEA, SKIN CANCER, PSORIASIS

IF YES, OR YOU HAVE A CONDITION THAT IS NOT LISTED ABOVE, PLEASE EXPLAIN: _____

INSURANCE INFORMATION PLEASE LIST YOUR INSURANCE COMPANIES IN ORDER THAT THEY SHOULD BE SUBMITTED, LIST THE COMPLETE ADDRESS ALONG WITH THE ID AND GROUP #. IF INSURANCE IS UNDER A SPOUSE OR PARENT, PLEASE HAVE THE POLICY HOLDERS SIGNATURE.

PRIMARY INSURANCE		SECONDARY INSURANCE	
ADDRESS		ADDRESS	
ID #	GROUP #	ID #	GROUP #
SIGNATURE OF POLICY HOLDER		SIGNATURE OF POLICY HOLDER	
POLICY HOLDERS DATE OF BIRTH	SS #	POLICY HOLDERS DATE OF BIRTH	SS #

I hereby authorize the release of pertinent medical information to Medicare or other insurance carriers. I also authorize my Medicare or other insurance benefits to be paid directly to the vision care provider. I understand that I am financially responsible for all co-pays, deductibles, and coinsurance amounts not covered by Medicare or other insurance carriers. Payment is due at the time services are rendered, unless payment arrangements have been approved in advance by our staff. On delinquent accounts, the undersigned agrees to pay all costs of collection, including an attorney's fee of 33 1/3% of the outstanding balance.

Signature of patient or responsible party

Date