Gilbert **Eyecare**
excellence in eyewear

Norfolk	**Virginia Beach**
220 W. Brambleton Ave. Ste. 111	1547 Laskin Road
Norfolk, Virginia 23510	VB, Virginia 23451
(757) 622-0200	(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	SOCIAL SECURITY #
SPOUSE/GUARDIAN NAME		RELATIONSHIP
PATIENT'S OCCUPATION	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? ○ YES ○ NO		

ALLERGIES

MEDS	YES - NO	YEAR IT STARTED
SULFA	○ YES - NO ○	
PENICILLIN	○ YES - NO ○	
ASPIRIN	○ YES - NO ○	
PAIN MED	○ YES - NO ○	
OTHER	○ YES - NO ○	
EYE DROPS	○ YES - NO ○	
SEASONAL	○ YES - NO ○	

MEDICATIONS

NAME OF MED	START DATE	DOSE	FREQUENCY	INDICTION
EG. METOPROL	2/26/01	25 MG	1X DAY	HIGH BP

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

CONTINUE ON PAGE 2

Patient's Medical History

SELF		FAMILY
☐	HIGH BLOOD PRESSURE_____YEARS	☐
☐	HEART DISEASE	☐
☐	DIABETES_____YEARS	☐
☐	CANCER	☐
☐	ARTHRITIS	☐
☐	RESPIRATORY DISEASE	☐
☐	ASTHMA	☐
☐	STROKE	☐
☐	MULTIPLE SCLEROSIS	☐
☐	HEADACHES #____PER MO	☐
☐	SICKLE CELL ANEMIA	☐
☐	CROHNS DISEASE	☐

Patient's Ocular History

SELF		FAMILY
☐	CATARACTS	☐
☐	GLAUCOMA	☐
☐	MACULAR DEGENERATION	☐
☐	STRABISMUS/EYE TURN	☐
☐	AMBLYOPIA/LAZY EYE	☐
☐	RETINAL DISORDERS	☐
☐	EYE INJURIES	☐
☐	EYE SURGERY	☐

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

_____

_____

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