Medical Medical Questionnaire

Patient's Name ______________________ Date of Birth __________ Sex: M / F
If Child, Parent's Name ______________________ Appointment Date ____________
SSN __________________ Email ___________________ Marital Status: Single/Married
Home Address______________________City ___________ State____Zip _________
Home Phone ____________ Cell Phone_____________ Work Phone _____________
Employer _________________________Occupation ___________________________
Medical Insurance Company __________________ ID Number___________________
Name of Policy Holder ______________________ Relationship: Self, Spouse, Parent
SSN: Policy Holder ______________________DOB: Policy Holder_______________

Personal Medical History:

Date of Last Medical Exam _________ Name of Family Physician _________________
Current Medications ____
____
Medication Allergies ____
List any Surgeries ____
Smoker: Yes or No Alcohol Use: None/Daily/Social

Circle any of the following medical conditions that you have:

Heart Disease High Blood Pressure High Cholesterol Stroke Diabetes Cancer
Asthma/Lung Disease Gastrointestinal Disorders Kidney/Bladder Disease Arthritis
Thyroid Disease Liver Disease Multiple Sclerosis Psychiatric Allergies Headaches

Ocular History:

Date of Last Eye Exam ___________ Location/Name of Optometrist _________________
Do you wear glasses? Yes or No If yes, how old is your current pair? _____________
Do you wear contact lenses? Yes or No Brand of contact lenses _________________
Are you interested in trying contact lenses or replacing contact lenses? ______________

Circle any of the following eye conditions that you have:

Cataracts Glaucoma Macular Degeneration Retinal Detachment Floaters LASIK
Lazy Eye Eye Surgery Blindness Blurred Vision Dry eye Double Vision Itchy Eyes
Tearing Eye Injury Glare Driving Difficulty

Family History: Circle any of the following conditions in your blood relatives:

Cataracts Glaucoma Macular Degeneration Retinal Detachment Lazy Eye Blindness
Heart Disease High Blood Pressure Diabetes Cancer

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges not covered by insurance. Payment is due at time the services are rendered.

Signature ____________________________________ Date ______________

I hereby acknowledge the receipt of the Notice of Privacy Practices from Optical Solutions effective date July 7, 2014.

Signature _____________________________________Date ______________

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