MEDICAL HISTORY QUESTIONNAIRE

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ______ Today's Date: ______

Address: ______ Home Phone: ______

City, State, Zip: ______ Work Phone: ______

Employer: ______ Cellular: ______

Birth Date: ______ Social Security #: ______ Occupation: ______

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow(er) ☐ Minor Last Eye Exam: ______

Name of Medical Doctor: ______ Doctor's Phone: ______

Spouse/Parent: ______ Spouse SS#: ______ Last Medical Exam: ______

Spouse Employer: ______ Referred by: ______

MEDICAL INSURANCE INFORMATION

Responsible Party: ☐ Self / ☐ Cash ☐ Check ☐ Visa ☐ Other: ______

☐ Vision Service Plan ☐ Medicare ☐ Medi-Cal ☐ Other Insurance: ______ Policy #: ______

☐ OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT Name of Responsible Party: ______

Address: ______ City/State/Zip: ______

What is their relationship to the patient? ______ Social Security Number: ______

Employed By: ______ Work Phone: ______ Home Phone: ______

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 all major injuries, surgeries and/or hospitalizations you have had: ______

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? ☐ NO ☐ YES **Do you wear glasses?** ☐ NO ☐ YES If yes, how old is your present pair of lenses? ______

Do you wear contact lenses? ☐ NO ☐ YES If yes, how old is your present pair of lenses? ______ Brand? ______

Type of contact lenses: ☐ Hard/Gas Perm ☐ Soft ☐ Extended Wear ☐ Other ______ ☐ Are they comfortable? ☐ NO ☐ YES

Would you like to be fitted with contacts? ☐ NO ☐ YES **Are you interested in laser corrective surgery?** ☐ NO ☐ YES

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

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

PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO

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 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, please 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: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

REVIEW OF SYSTEMS

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

SYSTEM	NO	YES	?
Constitutional			
Fever, Weight Loss/Gain	❑	❑	❑
Neurological			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
Eyes			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision/Halos	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy or Gritty Feeling	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excess Tearing/Watering	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Styes or Chalazion	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑

SYSTEM	NO	YES	?
Endocrine			
Thyroid/Other Glands	❑	❑	❑
Ears, Nose, Mouth, Throat			
Allergies/Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Respiratory			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Vascular/Cardiovascular			
Diabetes	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
Bones/Joints/Muscles			
Rheumatoid Arthritis	❑	❑	❑
Lymphatic/Hematologic			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
Allergic/Immunologic	❑	❑	❑
Psychiatric	❑	❑	❑
Disability	❑	❑	❑
Condition ____________			

If you have a condition not listed, please explain: ____________________

____

Doctor's Signature ____________________ **Date** ____________

- → **DEDUCTIBLE:** Patients are responsible for all deductibles. *Example: Medicare $100.00 Deductible or VSP Insurance Deductible*
- → **EXCEPTIONS / NON-COVERED SERVICES & MATERIAL FEES:** Patients are responsible for all non-covered services and materials at the time of service. The patient is also responsible for any denied services or materials.
- → **MEDICARE DOES NOT COVER DELUXE FRAMES:** Medicare *will allow you, if you wish, to pay the difference between the standard frame and a deluxe frame.*
- → **HMO, IPA, MANAGED CARE, PPO:** If you are enrolled in any of the above please make sure Dr. Gutierrez's office is on the provider panel and that you will be covered, otherwise you will be responsible for all services (exams) and materials (glasses, contacts, repairs, etc.)
- → **AUTHORIZATION STATEMENT SIGNATURE:** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also hereby assign directly to Dr. Gutierrez all vision/medical/eye appliance benefits, if any, otherwise payable to me for services or materials rendered.

I have read and understand the information above and agree to pay for any services and materials I order.

Patient/Beneficiary Signature ____________________ **Date** ____________