

Clarke EyeCare Medical History Questionnaire

If you are new to our practice, please choose how you were referred:

Location Internet Phone Book Insurance Mail Outs Television Patient (*name*): _____

Name of VISION insurance: _____	Name of MEDICAL insurance: _____
Name of Insurance subscriber: _____	Relationship to patient: _____
SSN# of ins subscriber: _____ - _____ - _____	Birth date of ins subscriber: _____ / _____ / _____
Employer of ins subscriber: _____	Work phone of ins subscriber: () _____ - _____

Patient Information

First name: _____ Middle initial: _____ Last name: _____ Preferred name: _____

Date of birth: Month _____ Day _____ Year _____ SSN#: _____ - _____ - _____ Gender (circle one): Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home: () _____ - _____ Cell: () _____ - _____ Work: () _____ - _____ Ext: _____

Employer: _____ Occupation: _____ Grade Level (if patient is a child): _____

Have we seen other members of your family? (*circle one*) YES / NO If yes, whom? _____

Is there anyone, besides yourself, that we may discuss your medical information with? If so, please list: _____

Signature: (*if over 18, or guardian*) _____ Today's date: _____ / _____ / _____

Medical History

Medical Doctor: _____ Last Medical Exam: _____ / _____ / _____

Last Eye Doctor: _____ Last Eye Exam: _____ / _____ / _____

Do you have any allergies to medication? **YES NO** If yes, explain: _____

List any medications you are currently taking (including RX and over the counter): _____

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 injuries: _____

Are you pregnant and / or nursing? **YES NO**

Do you wear glasses? **YES NO** If yes, how old are your current lenses? _____

Do you wear contact lenses? **YES NO** If yes, how old are your current lenses? _____

Type of contact lenses: Rigid Soft Extended Other Are your lenses comfortable? _____

Are you interested in new Glasses or Contact Lenses? _____

Eye Health	Are you <i>currently</i> or have you <i>ever</i> had any problems in the following areas?				
	Y	N		Y	N
Loss of Vision			Mucous Discharge		
Double Vision			Foreign Body Sensation		
Red Eyes			Eye Pain or Soreness		
Excess Tearing			Infection of Eye or Lid		
Itching/Burning Eyes			Stye or Chalazion		
Glare/ Light Sensitivity			Flashes in Vision		
Sandy or Gritty Sensation			Floaters in Vision		

Family History — In the space provided, please specify any family history for the following conditions: (Parents, Grandparents, etc.)

<input type="checkbox"/> Blindness	<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Lupus
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other

Review of Systems — Do you <i>currently</i> have any problems in the following areas?	YES	NO	Details
General/Constitutional -fever, heat stroke weight loss or gain, constant fatigue			
Ears/Nose/Throat -hearing loss, stuffy nose, earache, cough, dry mouth			
Cardiovascular -high blood pressure, racing pulse, etc.			
Gastrointestinal -stomach upset, diarrhea, constipation, hernia, ulcers			
Genital/Kidney/Bladder -painful urination, frequent urination, impotence, yellow jaundice, etc.			
Muscles/Bones/Joints -joint pain, stiffness, swelling, cramps, arthritis			
Skin -pimples, warts, growths, rash, etc.			
Neurological -numbness, headaches, seizures, paralysis, etc.			
Psychiatric -anxiety, depression, insomnia, etc.			
Endocrine -diabetes, hypothyroid, etc.			
Blood/Lymph -bleeding, cholesterolemia, anemia, problems from blood transfusions, HIV, etc.			
Allergic/Immunologic -sneezing, swelling, redness, itching, hives, etc.			