Vision Source

Medical History Questionnaire

May Vision Center
330 N. Century Ave
Waunakee, WI 53597

Name: _____ Birth Date: _____ Today's date: _____

Address _____ City _____ Zip _____

Phone Number: _____ Work Number: _____ Cell Number: _____

E-Mail address: _____ Referred by: _____

Previous Eye Doctor: _____ Last Eye Exam: _____

Current Medical Doctor: _____ Last Medical Exam: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Medical History

Would you like to access your medical file by computer? ☐ Yes ☐ No

Do you have any allergies to medications? ☐ Yes ☐ No 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: _____

Check any of the following that you have had: ☐ Reading Difficulty ☐ Crossed Eyes ☐ Lazy Eye ☐ Glaucoma
☐ Retinal Disease ☐ Cataracts ☐ Eye Injury ☐ Macular Degeneration

Are you pregnant and/or nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of glasses? _____
Are you interested in purchasing glasses today? _____

Do you wear contact lenses? ☐ Yes ☐ No If no, would you like to try contact lenses? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended wear ☐ Other Are they comfortable? ☐ Yes ☐ No

Have you had refractive or any eye surgery ☐ Yes ☐ No If yes, what kind _____

At work: Do you perform fine or close-up work? ☐ Yes ☐ No

Do you use a computer? ☐ Yes ☐ No If yes, how many hours? _____

Are you outdoors all or part of the time? ☐ Yes ☐ No

Is safety protection a concern at work? ☐ Yes ☐ No

Do you have trouble reading signs when driving at night? ☐ Yes ☐ No

Are you bothered by the glare from: Overhead lighting ☐ Yes ☐ No

A computer screen ☐ Yes ☐ No

On coming headlight at night ☐ Yes ☐ No

Are you sensitive to bright sunlight? ☐ Yes ☐ No Are you interested in purchasing sunglasses? __

What hobbies or recreational sports do you enjoy? _____

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? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No If yes, please describe: _____

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 recreational drugs? ☐ Yes ☐ No If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ No, I have not.

Please turn this form over and complete Side 2

Review of Systems Do you or your family currently, or have you ever had any problems in the following areas:

System	Yes	No	Family	Not Sure
Cancer	☐	☐	☐	☐
Constitutional				
Fever, Weight Loss/Gain	☐	☐	☐	☐
Skin (Integumentary)	☐	☐	☐	☐
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/Lid	☐	☐	☐	☐
Sty or Chalazion	☐	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐	☐
Endocrine				
Thyroid/Other Glands	☐	☐	☐	☐
Psychiatric	☐	☐	☐	☐

System	Yes	No	Family	Not Sure
Ears, Nose, Mouth, Throat				
Allergies/Hay Fever	☐	☐	☐	☐
Sinus Congestion	☐	☐	☐	☐
Runny Nose	☐	☐	☐	☐
Post-Nasal Drip	☐	☐	☐	☐
Chronic Cough	☐	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐	☐
Respiratory				
Asthma	☐	☐	☐	☐
Chronic Bronchitis	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Vascular/Cardiovascular				
Diabetes	☐	☐	☐	☐
Heart Pain	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Vascular Disease	☐	☐	☐	☐
Brain Injury/Stroke	☐	☐	☐	☐
Gastrointestinal				
Diarrhea	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Genitourinary				
Kidney/Bladder	☐	☐	☐	☐
Bones/Joints/Muscles				
Rheumatoid Arthritis	☐	☐	☐	☐
Muscle Pain	☐	☐	☐	☐
Joint Pain	☐	☐	☐	☐
Lymphatic/Hematologic				
Anemia	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐
Allergic/Immunologic	☐	☐	☐	☐

Assignment & Release

I acknowledge that I received a copy of May Vision Center's Notice of Privacy Practices. I authorize the release of any medial information necessary to process all claims. I also authorize the release of payment of medical benefits to my physician and understand I am responsible for non-covered services.

Signed _____ Date _____

"Thank you for completing this history form. The doctor and technicians will review your entries and ask you further questions where necessary. The doctor will then customize an examination just for you! The examination will enable us to meet your specific needs. Thank you again for choosing our office. We look forward to improving the quality of your life!"

I have reviewed this history with the patient: _____

Doctor's Signature / Date