**Medical/Vision History Questionnaire Hudson Valley Eye Doctor**

Last First Today’s Date

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Eye Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Eye Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Brings you in today??\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses [ ] NO [ ] YES If yes, how old is your present pair of glasses?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses [ ] NO [ ] YES How old is the pair of lenses you are wearing today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of contact lenses: [ ]Ridgid [ ] Soft [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are they comfortable [ ] NO [ ] YES

What type/brand of contact lens disinfection system do you use?

**VISION EXAM** Without Glasses or Contact lenses With Glasses With Contact Lenses

How is your vision? Clear / Not Clear Clear / Not Clear Clear / Not Clear

Distance Vision Clear / Not Clear Clear / Not Clear Clear / Not Clear\_\_\_\_\_

Near Vision Clear / Not Clear Clear / Not Clear Clear / Not Clear

Computer,phone,tablet Clear / Not Clear Clear / Not Clear Clear / Not Clear\_\_\_\_\_

**Refraction is the determination of your eyeglass prescription. This may be covered under your vision benefit for a Routine Eye Care. If you are here for an eye health issue and you will be using your medical insurance, and want glasses or a fitting for contact lenses, there will be a charge.**

***If you have any of symptoms below, they require a medical visit and will be billed to your medical coverage. Evaluation and treatment are not routine and are not covered under your routine vision benefit. Treatment and care,* *follow-up visits may be necessary. You will be responsible for any co-pays or deductibles.\_***

**Do you have problems with the following areas? If yes, please provide information.**

Loss of Vision NO YES Excessive Tearing NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blurred Vision NO YES Glare/light sensitivity NO YES \_\_\_

Distorted vision NO YES Eye pain or soreness NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Double Vision NO YES Infection of eye or lid NO YES \_\_\_\_\_\_\_\_\_\_\_\_\_

Mucous discharge NO YES Tired Eyes NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Redness NO YES Crossed eyes, lazy eye NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sandy or gritty NO YES Drooping Eyelid NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_

Itching NO YES Flashes/Floaters NO YES \_\_\_\_\_\_\_\_\_\_\_\_\_

Burning NO YES Other NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Foreign body

Sensation NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medial History:**

**Last Medical Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any Allergies or Allergies to Medication [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diabetes [ ] NO [ ] YES TYPE 1 (Insulin dependent) TYPE 2 (Non-Insulin dependent) Years Diabetic\_\_\_\_\_\_\_\_\_\_\_**

**Last Blood Sugar:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_A1C\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Diabetes is a medical diagnosis and requires a medical visit including testing and imaging. Diabetic evaluation is not part of a routine vision care visit. It will require a scheduled appointment separate from your vision benefit exam.\_\_\_***

**Females: Are you pregnant and or nursing [ ] NO [ ] YES**

***LIST ALL MEDICATIONS* Surgeries**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Pharmacy and location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY: This information is kept strictly confidential.**

**Tobacco products [ ] NO [ ] YES Alcohol [ ] NO [ ] YES**

**Non-prescribed drugs [ ] NO [ ] YES STD’S [ ] NO [ ] YES**

**Hepatitis [ ] NO [ ] YES HIV [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Review of Systems FAMILY HISTORY Parent(P) Grandparent (GP)**

**EAR, NOSE, MOUTH, THROAT [ ] NO [ ] YES Sibling (S) (living or deceased) \_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Allergies/ Hayfever [ ] NO [ ] YES Blindness [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_**

 **Sinus [ ] NO [ ] YES Cataract [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_**

 **Chronic Cough [ ] NO [ ] YES Crossed Eye [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_**

 **Dry Throat/Mouth [ ] NO [ ] YES Macular Degeneration [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_**

**RESPIRATORY Retinal Detachment [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_**

 **Asthma [ ] NO [ ] YES Glaucoma [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_**

 **Chronic Bronchitis [ ] NO [ ] YES Arthritis [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_**

 **Emphysema [ ] NO [ ] YES Cancer [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_**

**VASCULAR/CARDIOVASCULAR Diabetes [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

 **Diabetes [ ] NO [ ] YES Heart Disease [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_**

 **Heart Pain [ ] NO [ ] YES High Blood Pressure [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

**GASTROINTESTINAL Kidney Disease [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

 **Diarrhea [ ] NO [ ] YES Auto-immune Disease [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

 **Constipation [ ] NO [ ] YES** **Thyroid Disease [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

**GENITO-URNIARY Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Genitals/ Kidney [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Bladder [ ] NO [ ] YES**

Current Occupation/ or School Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Single [ ]Married [ ]Widowed [ ] Divorced Living Arrangements (asked only to determine if assistance is needed for the visually disabled).

**BONES/JOINT/MUSCLES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Rheumatoid Arthritis [ ] NO [ ] YES**

 **Muscle/Joint Pain [ ] NO [ ] YES**

**LYMPHATIC/HEMATOLOGIC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Anemia [ ] NO [ ] YES**

 **Bleeding [ ] NO [ ] YES**

**PSYCHIATRIC [ ] NO [ ] YES**