GRANDVILLE Eye Care, PC

Medical History Questionnaire

Today's Date _____ / _____ / _____

Name _____

Address _____ Phone _____

_____ Email _____

Birth Date _____ / _____ / _____ Soc Sec No. _____ - _____ - _____ Last Eye Exam _____ / _____ / _____

Name of Medical Doctor _____ Dr.'s Phone _____

Preferred Pharmacy/Location _____ Last Medical Exam _____ / _____ / _____

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 or nursing? ❑ No ❑ Yes

Do you wear glasses? ❑ No ❑ Yes If yes, how old is your current pair of lenses? _____

Do you wear contact lenses? ❑ No ❑ Yes If yes, how old is your current pair of lenses? _____

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ No ❑ Yes

Family History

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

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	_____
Cataract	❑	❑	❑	_____
Crossed Eyes	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment/Disease	❑	❑	❑	_____
Arthritis	❑	❑	❑	_____
Cancer	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
Heart Disease	❑	❑	❑	_____
Lupus	❑	❑	❑	_____
Thyroid Disease	❑	❑	❑	_____
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 or legal recreational 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	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
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	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes / Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
CONSTITUTIONAL			
Thyroid / Other Glands	❑	❑	❑

SYSTEM	NO	YES	?
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	❑	❑	❑
GASTROINTESTINAL	❑	❑	❑
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENITOURINARY	❑	❑	❑
Genitals / Kidney / Bladder	❑	❑	❑
BONES / JOINTS / MUSCLES	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC / HEMATOLOGIC	❑	❑	❑
Anemia	❑	❑	❑
Bleeding Problems			
ALLERGIC / IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

If you answered YES to any of the above or have a condition not listed, please explain and list medication:

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date

GRANDVILLE
Eye Care, PC

Responsible Party

Who is responsible for the account? (after insurance - Check ❑ if same as Patient).
Name _____ Relationship to Patient _____
Birth Date _____ / _____ / _____ Soc Sec No. _____ - _____ - _____
Address _____
City _____ State _____ Zip _____

Emergency Contact

In the event of an emergency, whom should we contact?
Name _____ Relationship to Patient _____
Home Phone _____ Work Phone _____

Authorization and Release

I authorize the release of any information, including the diagnosis and records of any treatment of examination rendered to me or my child during the period of such care to third party payers and / or health practitioners.
I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of Patient or Parent if minor Date

Privacy Practices

Thank you very much for taking the time to review how we are carefully using your health information. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Patient Name (Print) _____
Signature _____ Date _____

Person(s) Allowed to Disclose Information

First Name	Last Name	Relationship	Phone Number

I give consent to release all my medical information pertaining to health and treatment.

Signature _____ Date _____