MEDICAL HISTORY QUESTIONNAIRE

Personal Information Date_____

Name_____ Home Phone_____

Mailing Address_____ Work Phone_____

Street Address_____ Cell Phone_____

City/State/Zip_____ Social Security No._____

Birth Date_____Age_____ Email Address_____

Sex: M/F ☐Married ☐Single ☐Widowed Occupation_____

Employer_____ Employer's Address_____

Husband, Wife, Parent or Guardian's Name_____

Medical Doctor_____ Last Medical Exam_____

Referred by_____

Date of Last Vision Exam_____ Optometrist_____

FEE POLICY

Exam fee or insurance co-payment amount is due on date of examination. A 50% deposit is required for glasses or contact lenses to be ordered. The balance is due when dispensed. I have read and understand the above fee policy. Initial___

I request that payment of authorized benefits be made either to me, or on my behalf, to Dr. Vierthaler Kessen for any services furnished me by her. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Admin. and its agents or to Dr. Vierthaler Kessen any information needed to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. Dr. Vierthaler Kessen is a CAP Provider for BCBS, Medicare and BCBS Plan 65. I understand that any deductible or fees not paid by insurance are totally the responsibility of the patient.

Do you have vision or Medicare insurance? ☐ No ☐ Yes

Do you have major medical insurance? ☐ No ☐ Yes ***Copy of insurance card required to process claim!***

Medical History

Do you have any allergies to medications? ☐ No ☐ Yes ☐ Unknown If yes, please list:_____

List any current medications, dosage and reason for taking (including oral contraceptives, aspirin, over the counter medication and vitamins/supplements):

_____

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

_____

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

Have you had cataract surgery? ☐ No ☐ Yes If yes, which eye ☐ Right Eye ☐ Left Eye

Date of Surgery? _____Doctor_____

Glasses Information *(check all that apply*)

What glasses do you own?

Backup pair	☐	Progressive lens	☐	Safety glasses	☐
Bifocals	☐	Single Vision near	☐	Sunglasses	☐
Single Vision Distance	☐	Sports glasses	☐	Trifocals	☐

Check any that currently apply

Allergic to nickel (frames)	☐	I do not want to wear glasses	☐	Seems like prescription has changed	☐
Need spare glasses	☐	Problems with current glasses	☐	Problems with glare	☐
Problems with night vision	☐	Need sunglasses with Polarization and UV	☐		

Contact Lens Information

What brand of contacts do you wear? _____ __

How old are your current contacts?_____

How often do you replace them? _____

How often do you remove them? _____

What solution do you use for storing? _____

Check any that currently apply

I do not want to wear contacts ☐

Seems like prescription has changed ☐

Interested in refractive laser surgery ☐

Problems with current contacts ☐

I would like to change my eye color ☐

How many hours per day do you wear your contacts? ☐8/10hrs ☐10/12hrs ☐12/14hrs ☐14/16hrs ☐ Other_____

Please turn this form over and complete side two

FAMILY HISTORY			**Relationship**
Crossed Eyes	☐ No	☐ Yes	_____
Lazy Eye	☐ No	☐ Yes	_____
Drooping Eyelid	☐ No	☐ Yes	_____
Prominent Eyes	☐ No	☐ Yes	_____
Glaucoma	☐ No	☐ Yes	_____
Cataracts	☐ No	☐ Yes	_____
Macular Degeneration	☐ No	☐ Yes	_____
Retinal Detachment/Disease	☐ No	☐ Yes	_____
Other			_____

FAMILY HISTORY			**Relationship**
Cancer	☐ No	☐ Yes	_____
Diabetes	☐ No	☐ Yes	_____
Arthritis	☐ No	☐ Yes	_____
Lupus	☐ No	☐ Yes	_____
Kidney Disease	☐ No	☐ Yes	_____
Heart Disease	☐ No	☐ Yes	_____
Thyroid	☐ No	☐ Yes	_____
High Cholesterol	☐ No	☐ Yes	_____
High Blood Pressure	☐ No	☐ Yes	_____

Review of Systems

Do ***YOU*** currently have, 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/Side Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Crossed Eyes	☐	☐	☐
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	☐	☐	☐
Drooping eyelids	☐	☐	☐
Lazy Eye	☐	☐	☐
Prominent Eyes	☐	☐	☐
Glaucoma	☐	☐	☐
Cataracts	☐	☐	☐
Macular Degeneration	☐	☐	☐
Retinal Detachment/Disease	☐	☐	☐
Cancer	☐	☐	☐

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	☐	☐	☐
High Cholesterol	☐	☐	☐
Heart Disease	☐	☐	☐
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			
Lupus	☐	☐	☐
Psychiatric	☐	☐	☐
Endocrine	☐	☐	☐
Thyroid/Other Glands	☐	☐	☐

If you have a condition not listed, please explain:

_____

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 ☐ No

_____

Patient/Guardian Signature Date