Virginia Vision Associates

MEDICAL HISTORY QUESTIONNAIRE

Dear Patient:
All major health insurers and Medicare now require us to obtain in-depth patient medical history information. We apologize for the time required to fill out this form and thank you for your cooperation.

Name _____ T**oday's Date**: _____/_____/_____

EYE AND HEALTH HISTORY

Reason for Visit ☐ routine annual exam ☐ need new glasses ☐ lost or broken glasses
☐ contact lenses ☐ interested in lasik laser vision correction

Do you have any specific questions or problems you would like to discuss with your doctor? ☐ yes ☐ no
If "yes," please explain: _____

Are you currently taking any medications? ☐ yes ☐ no
If "yes," please list: _____
Are you allergic to any medications? ☐ yes ☐ no
If "yes," please explain: _____

Are you pregnant and/or nursing? ☐ yes ☐ no _____

PERSONAL EYE HISTORY

Date of Last Eye Examination: _____ Doctor's Name: _____
Have you ever worn glasses? ☐ yes ☐ no If "yes," how old are your current glasses? _____
Do you currently wear contact lenses? ☐ yes ☐ no
Type of contact lenses: ☐ disposables ☐ gas perm ☐ soft ☐ bifocal ☐ other _____
What type of solution do you use to clean and disinfect? _____
Have you worn contact lenses in the past? ☐ yes ☐ no If "yes," please tell us why you quit _____
Have you ever had lasik or retractive surgery? ☐ yes ☐ no If yes, date: _____/_____/_____
Have you ever had eye surgery? ☐ yes ☐ no If "yes," please describe: _____
Check any of the following that you have had: ☐ crossed eyes ☐ lazy eye ☐ drooping eyelid
☐ prominent eyes ☐ glaucoma ☐ retinal disease
☐ cataracts ☐ eye injury ☐ serious eye infection
How many hours a day do you work on a computer? _____

Please check all applicable items:

Blurred distance vision	Eyes feel dry	Headaches
Blurred intermediate vision	Pain in eyes	Light sensitivity
Blurred near vision	Flashes of lights	Eyes water
Night vision problems	Floating spots in vision	Eyes itch
Double vision	Eyes feel tired	

Please mark those activities in which you participate:

Tennis	Basketball	Skiing	Football	Dancing	Woodworking
Soccer	Swimming	Hunting	Fishing	Golf	Rollerblading
Biking	Racquetball	Walking	Scuba Diving	Reading	Baseball
Gardening	Crafts	Jogging	Sewing	Aerobics	Musical Instrument

(over)

REVIEW OF SYSTEMS

Do you currently, or have you ever, had any serious problems in the following areas:

	Yes	No		Yes	No
Diabetes	☐	☐	Blood	☐	☐
High Blood Pressure	☐	☐	Endocrine (Thyroid)	☐	☐
Neurological (Headaches)	☐	☐	Ears, Nose, Mouth, Throat (Allergies)	☐	☐
Cholesterol	☐	☐	Respiratory	☐	☐
Eyes	☐	☐	Cardiovascular	☐	☐
Cancer	☐	☐	Gastrointestinal	☐	☐
Skin	☐	☐	Muscoloskeletal	☐	☐
Allergic/Immune	☐	☐	Mental	☐	☐
Genitourinary	☐	☐	Other: _____		

Have you been exposed to or infected with any of the following:

☐ Lyme Disease ☐ HIV ☐ Hepatitis

If you answered "yes" to any of the above or are currently under the care of a physician for any condition not listed above, please explain: _____

_____

Physician's Name: _____ Phone #:_____

SOCIAL HISTORY

This information is kept strictly confidential. Please answer all questions that apply.

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 Do you drink alcohol? ☐ yes ☐ no

Do you use illegal drugs? ☐ yes ☐ no

FAMILY HISTORY

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

Disease/Condition	Yes	No	Relationship to You
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Cataract	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____
Crossed Eyes	☐	☐	_____
Blindness	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Heart Disease	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Thyroid Disease	☐	☐	_____

Other: _____

I acknowledge that I have been made aware of the HIPPA Notice of Privacy Practices.

Patient Name: _____ Signature: _____ Date _____

Doctor's Signature: _____ Date: _____