

# MEDICAL HISTORY QUESTIONNAIRE

## New York Vision Associates Inc.

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

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Employer \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Occupation: \_\_\_\_\_

Email Address: \_\_\_\_\_

Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical Doctor: \_\_\_\_\_

Last Medical Exam: \_\_\_\_\_

Referred By: \_\_\_\_\_

**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, or circle any of the following that you have had: crossed eye, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataract, eye infection or eye injury: \_\_\_\_\_

Are you pregnant and/or nursing?  no  yes

Do you wear glasses?  no  yes If yes, how old; glasses? \_\_\_\_\_

Do you wear contact lenses?  no  yes If yes, how old; contacts? \_\_\_\_\_

Type of contact lenses:  Rigid  Soft  Disposable  Other Are they comfortable?  yes  no

**Family History**

Please note any family history (parents, grandparents, siblings, children; living or deceased)

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Medical Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_ Grp #: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_ Insured DOB: \_\_\_\_\_