

Medical History Questionnaire

PATIENT INFORMATION

Date: _____
Name _____ DOB _____
Address _____
City/State/Zip _____
Phone: (H): _____ (W): _____ (C): _____ SSN: 000-00- _____ (last four digits only)

RESPONSIBLE PARTY INFORMATION (If different from patient)

Name _____ DOB _____
Address _____
City/State/Zip _____
Phone: (H): _____ (W): _____ (C): _____ SSN: 000-00- _____ (last four digits only)

INSURANCE INFORMATION

Plan Name: _____ ID# _____
Policy Holder Name _____
Plan Name: _____ ID# _____
Policy Holder Name _____
How were you referred to our office? _____
E-mail address (to be used ONLY for sending requested information) _____
Primary Care Physician: _____ PH# _____

It is our goal at Gontarek Eye Care to provide not only the finest vision care available, but also provide financial services that do not cause undue hardship for our patients. I understand that I am financially responsible for all charges incurred for services rendered by Gontarek Eye Care. When these services are not covered by insurance, including all costs incurred to collect delinquent charges as well as collection fees of 33.3% I am responsible. I request that payments of authorized Medicare or other benefits be made either to me or on my behalf of Gontarek Eye Care for any services furnished by Gontarek Eye Care. We must emphasize that as a vision care provider our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

SIGNATURE _____ DATE _____

MEDICAL HISTORY

Do you have any allergies to medications? No Yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin and over the counter medications and home remedies): _____

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

Check any of the following that you have had: _____ Crossed Eyes _____ Lazy Eye _____ Drooping Eyelid _____ Prominent Eyes
_____ Glaucoma _____ Retinal Disease _____ Cataracts _____ Eye Infections _____ Eye Injuries: _____

Yes No Are you pregnant and/or nursing? _____

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

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

What type of contact lenses do you wear? Soft Rigid Extended Wear Disposable

How often do you dispose of your lenses? _____ x day _____ x week _____ x month

FAMILY

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

Disease/Condition	Self	Family	Relation (mother, father, sister...)	Self	Family	Relation
Blindness	_____	_____	_____	Cancer	_____	_____
Cataract	_____	_____	_____	Diabetes	_____	_____
Crossed Eyes	_____	_____	_____	Heart Disease	_____	_____
Glaucoma	_____	_____	_____	High Blood Pressure	_____	_____
Macular Degeneration	_____	_____	_____	Kidney Disease	_____	_____
Arthritis	_____	_____	_____	Lupus	_____	_____
Thyroid Disease	_____	_____	_____	Other: _____	_____	_____

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 this information directly with the doctor. (Check box)

Yes No Do you drive? If yes, do you have visual difficulty when driving? Yes No If yes, please describe:

Yes No Do you use tobacco products? If yes, type/amount/how long? _____

Yes No Do you drink alcohol? If yes, type/amount/how long? _____

Yes No Do you use illegal drugs? If yes, type/amount/how long? _____

Have you ever been exposed to the following: _____ Gonorrhea _____ Hepatitis _____ HIV _____ Syphilis

Review of Systems:

Do you currently, or have you ever had any significant problems in the following areas?

System	No	Yes	?	System	No	Yes	?
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever, Weight Loss/Gain	_____	_____	_____	Allergies/Hay Fever	_____	_____	_____
Integumentary (Skin)	_____	_____	_____	Sinus Congestion	_____	_____	_____
NEUROLOGICAL				Runny Nose	_____	_____	_____
Headaches	_____	_____	_____	Post Nasal Drip	_____	_____	_____
Migraines	_____	_____	_____	Chronic Cough	_____	_____	_____
Seizures	_____	_____	_____	Dry Throat/Mouth	_____	_____	_____
EYES				RESPIRATORY			
Loss of Vision	_____	_____	_____	Asthma	_____	_____	_____
Blurred Vision	_____	_____	_____	Chronic Bronchitis	_____	_____	_____
Distorted Vision/Halos	_____	_____	_____	Emphysema	_____	_____	_____
Loss of Side Vision	_____	_____	_____	VASCULAR/CARDIOVASCULAR			
Double Vision	_____	_____	_____	Diabetes	_____	_____	_____
Dryness	_____	_____	_____	Heart Pain	_____	_____	_____
Mucous Discharge	_____	_____	_____	High Blood Pressure	_____	_____	_____
Redness	_____	_____	_____	Vascular Disease	_____	_____	_____
Sandy or Gritty Feeling	_____	_____	_____	GASTROINTESTINAL			
Itching	_____	_____	_____	Diarrhea	_____	_____	_____
Burning	_____	_____	_____	Constipation	_____	_____	_____
Foreign Body Sensation	_____	_____	_____	GENITOURINARY			
Excess Tearing/Watering	_____	_____	_____	Genitals/Kidney/Bladder	_____	_____	_____
Glare/Light Sensitivity	_____	_____	_____	BONES/JOINTS/MUSCLES			
Eye Pain or Soreness	_____	_____	_____	Rheumatoid Arthritis	_____	_____	_____
Chronic Infection	_____	_____	_____	Muscle Pain	_____	_____	_____
Sties or Chalzion	_____	_____	_____	Joint Pain	_____	_____	_____
Flashes/Floaters in Vision	_____	_____	_____	LYMPHATIC/HEMATOLOGIC			
Tired Eyes	_____	_____	_____	Anemia	_____	_____	_____
ENDOCRINE				Bleeding Problems	_____	_____	_____
Thyroid/Other Glands	_____	_____	_____	PSYCHIATRIC			

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

Doctor's Signature: _____ Date: _____