Medical History Questionnaire

Please Fill Out Completely

Name:_____ Today's Date:_____/_____/_____

Preferred Name:_____ Phone numbers: (c) _____

Address:_____ (h)_____

_____ w) _____

City _____State: _____ Zip: _____ Birthday: _____/_____/_____

E-mail: _____ May we contact you via e-mail: □ Yes □ No

Occupation: _____ Race: _____ Ethnicity: _____

Legal Sex: □ Female □ Male Pronouns: _____ Gender: _____

While InVision recognizes many genders and sexes, many insurance companies unfortunately do not. Please let us know your preferred name.

Do you have vision insurance? □ Yes □ No Type: _____

Primary on vision insurance: _____ Primary's last four of SSN: _____

Do you have medical insurance? □ Yes □ No Type: _____

Primary on medical insurance: _____ Primary's last four of SSN: _____

Last 4 digits of your social security number (insurance purposes): _____

You are responsible for knowing your vision and medical insurance benefits, keeping track of your eligibility and verifying insurance will cover the service.

Primary Care Physician: _____ Diabetic Physician_____

Whom may we thank for referring you to our office? _____

What hobbies or recreational sports do you enjoy? _____

Marital Status: Married Single Widowed Divorced Emergency Contact: _____

Visual Information – Check any of the following that you have had:

□ **Reading Difficulty**	□ **Crossed Eyes**	□ **Lazy Eye**	□ **Pain**
□ **Eye Injury/Abrasion**	□ **Glaucoma**	□ **Retinal Disease**	□ **Cataracts**

Do you wear glasses? □ Yes □ No If yes, how old is your pair of glasses? _____
Do you wear contact lenses? □ Yes □ No If yes, how old is your current pair of CLs? _____
Are you having problems with your current glasses or contacts prescription? □ Yes □ No
Have you had refractive surgery (ie – LASIK)? □ Yes □ No

General Medical

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

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

_____

List any ocular medications (Including OTC eye drops, glaucoma medications, and allergy drops):_____

_____

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

_____

Social History

Do you use tobacco products? □ Yes □ No If yes, type/amount _____
Do you drink alcohol? □ Yes □ No If yes, type/amount _____
Do you use recreational drugs? □ Yes □ No If yes, type/amount_____

Family History—Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	Yes	No	Not Sure	Relationship To You
Blindness	□	□	□	_____
Cataract	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment	□	□	□	_____
Retinal Disease	□	□	□	_____
Systemic Disease/Condition				
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Thyroid Disease	□	□	□	_____

Medical History- Do you currently, or have you ever had problems in the following areas?

System	Yes	No	Not Sure
Eyes			
Loss of Vision	□	□	□
Blurred Vision	□	□	□
Distortion/Halos	□	□	□
Loss of Side Vision	□	□	□
Double Vision	□	□	□
Dryness	□	□	□
Mucous Discharge	□	□	□
Redness	□	□	□
Sandy/Gritty Feeling	□	□	□
Itching	□	□	□
Burning	□	□	□
Foreign Body Sens.	□	□	□
Watery Eyes	□	□	□
Glare	□	□	□
Light Sensitivity	□	□	□
Eye Pain/Soreness	□	□	□
Chronic Infection	□	□	□
Sty/Eyelid Infection	□	□	□
Flashes/Floaters	□	□	□
Tired Eyes	□	□	□
Skin			
Eczema	□	□	□
Rosacea	□	□	□
Psoriasis	□	□	□
Neurological			
Headaches	□	□	□
Migraines	□	□	□
Seizures	□	□	□
Endocrine			
Hyperthyroid	□	□	□
Hypothyroid	□	□	□
Psychiatric			
Depression	□	□	□
OCD	□	□	□
Manic/Depressive	□	□	□

System	Yes	No	Not Sure
Ears, Nose, Mouth Throat			
Chronic Cough	□	□	□
Sinus Congestion	□	□	□
Respiratory			
Asthma	□	□	□
Bronchitis	□	□	□
Emphysema	□	□	□
Vascular/Cardiovascular			
Diabetes	□	□	□
High Blood Pressure	□	□	□
Vascular Disease	□	□	□
Brain Injury/Stroke	□	□	□
High Cholesterol	□	□	□
Gastrointestinal			
Stomach/Intestinal	□	□	□
Genitourinary			
Genital/Kidney	□	□	□
Bones/Joints/Muscles			
Rheumatoid Arthritis	□	□	□
Muscle Pain	□	□	□
Joint Pain	□	□	□
Lymphatic/Hematologic			
Anemia	□	□	□
Cancer	□	□	□
Clotting Problems	□	□	□
Sickle Cell	□	□	□
Allergic/Immunologic			
Seasonal Allergies	□	□	□
Hay Fever	□	□	□

Please list any other medical concerns: _____