VISION PLUS
HEALTH QUESTIONARE

PATIENT NAME: _____ DATE: _____

PRIMARY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

PATIENT DATE OF BIRTH: _____ SEX: M or F MARITAL STATUS: _____

PATIENT EMPLOYER: _____ EMPLOYER PHONE NUMBER: _____

PATIENT SOCIAL SECURITY NUMBER: _____ EMERGENCY CONTACT: _____

EMERGENCY CONTACT PHONE NUMBER: _____ RELATIONSHIP: _____

HOW DID YOU HEAR ABOUT US?

INTERNET SEARCH _____ OUR WEBSITE _____ RADIO _____ NEWSPAPAER _____

INSURANCE COMPANY _____ OTHER _____ REFERRED BY M.D. (Dr. Name) _____

REFERRED BY OPHTHALMOLOGIST (Dr. Name) _____

REFERRED BY FRIEND/FAMILY _____

DO YOU WEAR GLASSES? _____ HOW OLD ARE THEY? _____

DO YOU WEAR CONTACT LENSES? _____ ARE THEY SOFT DISPOSABLE / RGP / OTHER? _____

HOW OLD ARE THEY? _____ WHAT BRAND ARE THEY? _____

DO YOU WANT TO BE FIT WITH CONTACT LENSES TODAY? _____

ARE YOU HAVING PROBLEMS WITH YOUR VISION, YOUR GLASSES OR YOUR CONTACT LENSES? PLEASE EXPLAIN:

_____

_____

HAVE YOU HAD YOUR EYES DILATED BEFORE? _____

MEDICAL HISTORY DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

1.	PREGNANT / NURSING	YES / NO	**10.**	EYE INFECTIONS	YES / NO	**18.**	RETINAL DETACHMENT	YES / NO
2.	INJURIES	YES / NO	**11.**	PROMINENT EYES	YES / NO	**19.**	RETINAL DISEASE	YES / NO
3.	ALLERGIES	YES / NO	**12.**	GLAUCOMA	YES / NO	**20.**	STROKE	YES / NO
4.	SURGERIES	YES / NO	**13.**	EYE INJURIES	YES / NO	**21.**	HEART DISEASE	YES / NO
5.	CATARACTS / SX	YES / NO	**14.**	HEADACHES	YES / NO	**22.**	HIGH BLOOD PRESSURE	YES / NO
6.	LAZY EYE	YES / NO	**15.**	MIGRAINES	YES / NO	**23.**	SEE SPOTS OR FLASHES	YES / NO
7.	DROOPY LIDS	YES / NO	**16.**	LASIK SURGERY	YES / NO	**24.**	THYROID PROBLEM	YES / NO
8.	CROSSED EYES	YES / NO	**17.**	DOUBLE VISION	YES / NO	**25.**	HEART ATTACK	YES / NO
9.	DIABETES	YES / NO ** TYPE I / TYPE II				**26.**	MEDICATIONS	YES / NO

IF YOU CIRCLED YES TO ANY OF THE ABOVE EXPLAIN AND LIST ANY MEDICATIONS: _____

_____

_____

FAMILY HISTORY HAS ANY MEMBER OF YOUR FAMILY BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

1.	BLINDNESS	YES / NO	**7.**	HEART DISEASE	YES / NO	**13.**	RETINAL DISEASE	YES / NO
2.	CATARACT	YES / NO	**8.**	HIGH BLOOD PRESSURE	YES / NO	**14.**	RETINAL DETACHMENT	YES / NO
3.	CROSSED EYES	YES / NO	**9.**	KIDNEY DISEASE	YES / NO	**15.**	MACULAR DEGENERATION	YES / NO
4.	GLAUCOMA	YES / NO	**10.**	THYROID DISEASE	YES / NO	**16.**	OTHER _____	
5.	DIABETES	YES / NO	**11.**	ARTHRITIS	YES / NO			
6.	LUPUS	YES / NO	**12.**	CANCER	YES / NO			

PLEASE EXPLAIN: _____

_____

SOCIAL HISTORY

DO YOU DRIVE? YES / NO DO YOU HAVE VISUAL DIFFICULTY WHILE DRIVING? _____
DO YOU USE TABACCO PRODUCTS? YES / NO DO YOU DRINK ALCOHOL? YES / NO DO YOU USE ILLEGAL DRUGS? YES / NO
HAVE YOU EVER BEEN EXPOSED TO OR INFECTED WITH: HEPATITIS or HIV? _____

REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas:

SYSTEM

CONSTITUTIONAL		**EARS, NOSE, MOUTH, THROAT**	
FEVER, WEIGHT LOSS/GAIN	Y / N	ALLERGIES/HAY FEVER	Y / N
INTEGUMENTARY (SKIN)	Y / N	SINUS CONGESTION	Y / N
NEUROLOGICAL		RUNNY NOSE	Y / N
HEADACHES	Y / N	POST-NASAL DRIP	Y / N
MIGRAINES	Y / N	CHRONIC COUGH	Y / N
SEIZURES	Y / N	DRY THROAT/MOUTH	Y / N
EYES		**RESPIRATORY**	
LOSS OF VISION	Y / N	ASTHMA	Y / N
BLURRED VISION	Y / N	CHRONIC BRONCHITIS	Y / N
DISTORTED VISION/HALOS	Y / N	EMPHYSEMA	Y / N
LOSS OF SIDE VISION	Y / N	**VASCULAR/CARDIOVASCULAR**	
DOUBLE VISION	Y / N	DIABETES	Y / N
DRYNESS	Y / N	HEART PAIN	Y / N
MUCOUS DISCHARGE	Y / N	HIGH BLOOD PRESSURE	Y / N
REDNESS	Y / N	VASCULAR DISEASE	Y / N
SANDY OR GITTY FEELING	Y / N	**GASTROINTESTINAL**	
ITCHING	Y / N	DIARRHEA	Y / N
BURNING	Y / N	CONSTIPATION	Y / N
FOREIGN BODY SENSATION	Y / N	**GENITOURINARY**	
EXCESS TEARING/WATERING	Y / N	GENITALS/KIDNEY/BLADDER	Y / N
GLARE/LIGHT SENSITIVITY	Y / N	**BONES/JOINTS/MUSCLES**	
EYE PAIN OR SORENESS	Y / N	RHEUMATOID ARTHRITIS	Y / N
CHRONIC INFECTION EYE/LID	Y / N	MUSCLE PAIN	Y / N
STIES OR CHALAZION	Y / N	JOINT PAIN	Y / N
FLASHES / FLOATERS IN VISION	Y / N	**LYMPHATIC/HEMATOLOGIC**	
TIRED EYES	Y / N	ANEMIA	Y / N
ENDOCRINE		BLEEDING PROBLEMS	Y / N
THYROID/OTHER GLANDS	Y / N	**ALLERGIC/IMMUNOLOGIC**	Y / N
		PSYCHIATRIC	Y / N

IF YOU ANSWERED YES TO ANY OF THE ABOVE OR HAVE A CONDITION NOT LISTED, PLEASE EXPLAIN & LIST MEDICATIONS: _____

_____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS OR OTHER INSURANCE BE MADE ETHER TO ME OR ON MY BEHALF TO DR. SMITH OR ANY SERVICES FURNISHED ME BY THAT DOCTOR. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASETO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

LIFETIME PATIENT SIGNATURE _____ DATE _____

DOCTOR SIGNATURE _____ DATE _____

REVIEWED PREVIOUS HISTORY (PERSONAL/FAMILY) AND TOTAL CASE RECORD. ANY CHANGES NOTED AND RECORDED IN ABOVE DATED VISIT. THIS VISIT PART OF TOTAL CASE RECORD.