EYE CARE PROFESSIONALS
"Nothing Is More Precious Than Your Vision"
2860 S. Alma School Rd. • Suite 28
Chandler, Arizona 85286

Today's Date: ____/____/____

(480) 732-9040 • (480) 782-9579 FAX
www.eyecareprofessionalsaz.com

Medical History Questionnaire

PATIENT

Mr./Mrs./Ms./Dr.____ (Please Circle)
Name of parent or Guardian:____ (If patient's a minor)
Address:____ Phone: ____ Work Phone:____
City:____ State:____ Zip:____ Email: ____
Birthdate:____/____/____ Age:____ Occupation:____

Who can we thank for referring you to our office? ____

INSURANCE

Primary member's name:____
*(Relationship to patient)*____
Address:____
City:____ State:____ Zip:____
E-mail:____
Social Security# of primary member: ____/____/____
Primarys DOB ____/____/____
Marital status: **M S D W**
Employer:____
Vision Insurance:____
Name of Major Medical Insurance:____ Please circle: **HMO PPO**

MEDICAL HISTORY

Name of Medical Doctor:____
Last Medical Exam: ____/____/____ Last Eye Exam:____/____/____
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 any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:____

Are you pregnant and/or nursing? ☐No ☐Yes
Do you wear glasses? ☐No ☐Yes If yes, how old is your present pair of glasses? ____
Do you wear contacts? ☐No ☐Yes If yes, how old is your present pair of lenses? ____
Type of contact lenses: ☐ Rigid ☐ Disposables ☐ Soft ☐ Extended wear
Name of contact lense cleaning system: ____ How many hours per day do you wear them?____
If disposable, how often do you replace them?____
What is the main problem you are experiencing with your vision?____

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 my social history information directly with my doctor.***

Do you drive? ☐No ☐Yes If yes, do you have difficulty when driving?____
If yes, please describe:____
Do you use tobacco products? ☐No ☐Yes
Do you drink alcohol? ☐No ☐Yes
Do you use illegal drugs? ☐No ☐Yes
Have you ever been exposed to or infected with: ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis

FAMILY HISTORY

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

REVIEW OF SYSTEMS

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

Systems	Yes	No	?
Constitutional			
fever, weight loss/gain	☐	☐	☐
Integumentary (skin)	☐	☐	☐
Neurological			
headaches	☐	☐	☐
migraines	☐	☐	☐
seizures	☐	☐	☐
Eyes			
loss of vision	☐	☐	☐
blurred vision	☐	☐	☐
distorted vision/haloes	☐	☐	☐
loss of side vision	☐	☐	☐
double vision	☐	☐	☐
dryness	☐	☐	☐
mucous discharge	☐	☐	☐
redness	☐	☐	☐
sandy or gritty feeling	☐	☐	☐
itching	☐	☐	☐
burning	☐	☐	☐
foreign body sensation	☐	☐	☐
excess tearing/watering	☐	☐	☐
glare/light sensitivity	☐	☐	☐
eye pain or soreness	☐	☐	☐
chronic infection of eye or lid	☐	☐	☐
sties or chalazion	☐	☐	☐
flashes/floaters in vision	☐	☐	☐
tired eyes	☐	☐	☐
Endocrine			
thyroid/other glands	☐	☐	☐

	Yes	No	?
Ears, Nose, Mouth, Throat	☐	☐	☐
allergies	☐	☐	☐
sinus congestion	☐	☐	☐
runny nose	☐	☐	☐
post-nasal drip	☐	☐	☐
chronic cough	☐	☐	☐
dry throat/mouth	☐	☐	☐
Respiratory			
asthma	☐	☐	☐
chronic bronchitis	☐	☐	☐
emphysema	☐	☐	☐
Vascular/Cardiovascular			
diabetes	☐	☐	☐
heart pain	☐	☐	☐
high blood pressure	☐	☐	☐
vascular disease	☐	☐	☐
Gastrointestinal			
diarrhea	☐	☐	☐
constipation	☐	☐	☐
Genitourinary			
genitals/kidney/bladder	☐	☐	☐
Bones/Joints/Muscles			
rheumatoid arthritis	☐	☐	☐
muscle pain	☐	☐	☐
joint pain	☐	☐	☐
Lymphatic/Hematologic			
anemia	☐	☐	☐
bleeding problems	☐	☐	☐
psychiatric			

Please list any conditions not listed above:_____

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Eye Care Professionals. P.C., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible party signature:_____ Relationship: _____ Date: _____