Stay Focused EyeCare History Questionnaire

All questions contained in this questionnaire can relate to your eye health.
All information is strictly confidential and will become part of your medical record.

Date:

Name:		☐ M ☐ F	DOB:	Last 4 SSN:
Address:		City:		Zip:
Phone:	W:	C:	H:	
Occupation:		Hobbies:		

How were you referred to our office today? Knowing who we can thank for your visit is important to us.

☐ Internet search: What did you search for? _____
☐ Your primary care doctor
☐ Friend/Relative
☐ Driving by our office
☐ Insurance carrier listing
☐ Facebook, Yelp, Patch, other social media
☐ Other

Ocular History

Date of last eye exam:	Previous or referring doctor:

Do you have, or have you had, any ocular problems listed below? If yes please briefly explain.
☐ **No past ocular conditions**

☐ Glaucoma
☐ Cataracts
☐ Macular degeneration
☐ Trauma or Injury
☐ Retinal Detachment or Retinal Disease
☐ Strabismus / Amblyopia / "Lazy eye"
☐ Diabetic eye disease
☐ Dry eye syndrome or Dry Eyes
☐ Uveitis / Iritis
☐ Keratoconus
☐ Laser Surgery
☐ Other eye surgery
☐ Other ocular problems:

Does anyone in your family have any of the conditions listed below? If so please list their relationship to you.

☐ Blindness
☐ Cataracts
☐ Macular degeneration
☐ Glaucoma
☐ Retinal Detachment
☐ Diabetic eye disease
☐ Strabismus / Amblyopia / "Lazy eye"
☐ Corneal disease:
☐ Other:

Do you wear glasses? ☐ yes ☐ no If yes, are they for ☐ Distance ☐ Near ☐ Both
Do you wear contact lenses? ☐ yes ☐ no
Are there any activities where you would like to see better?
Are there any activities that irritate or bother your eyes?

CONTINUED ON BACK...

Personal Health History

Primary Care Physician: | Date of last physical exam:

Do you currently have or have you had the following health conditions? ☐ I have no current health conditions

General Health
- ☐ Headaches
- ☐ Head Trauma
- ☐ Cancer:_____
- ☐ Seizures

Endocrine
- ☐ Diabetes, Type ☐ 1 ☐ 2
- Last blood sugar reading _____
- Last HbA1C reading _____%
- ☐ High/Low Thyroid Function

Cardiovascular
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Stroke

Skin/Integument
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Eczema
- ☐ Shingles

Neurologic
- ☐ Multiple Sclerosis
- ☐ Migraine

Gastrointestinal / Digestive
- ☐ Crohn's Disease
- ☐ IBS

Allergic
- ☐ Seasonal/Environmental allergies

Ear / Nose / Throat
- ☐ _____

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Sarcoidosis

Musculoskeletal
- ☐ Osteoarthritis

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Lymphoma

Immunologic
- ☐ Sjogren's Syndrome
- ☐ Lupus
- ☐ Rheumatoid Arthritis

Women: Are you currently pregnant? ☐ yes ☐ no

Other Conditions:

Has anyone in your family ever been diagnosed or treated for any of the following health problems? If yes, please list who.

☐ High blood pressure ☐ Heart Disease ☐ Diabetes

Other:

Do you use tobacco? ☐Yes ☐No Do you drink alcohol? ☐Yes ☐ No Do you use illegal drugs? ☐ Yes ☐ No

Have you ever been exposed to or infected with: Gonorrhea ☐Yes ☐ No Hepatitis ☐Yes ☐ No HIV ☐Yes ☐ No Syphilis ☐Yes ☐ No

Please list your prescribed drugs including birth control and over-the-counter drugs including vitamins, aspirin and inhalers. ☐ **None**

If you can provide your own list of medications please provide it to us and you can skip this step.

Name of the Drug	Reason for Taking	Strength	Frequency Taken

Do you have any allergies to medications? If yes, note which below. ☐No

1) We will do all we can to find out what your vision insurance benefits are and what you are eligible for. We will also submit your claim for you when possible. The information given to us by your insurance company is not a guarantee of payment from them. If your insurance company does not pay this amount it will be your responsibility to pay your balance.
2) I acknowledge that I have received and reviewed a copy of Stay Focused EyeCare's Notice of Privacy Practices.
3) I certify that the information I have reported above is correct.

Signature: _____ Date: _____