Medical History Questionnaire

Address	Name						_ Today's Date//
City	Address						Home Phone
Birth Date	City		State	,	Zip.		Cell Phone
Medical History Do you have any allergies to medications? no ges If yes, explain: List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): List any major injuries, surgeries and/or hospitalizations you have had: List any of the following that you have had: crossed/turned eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: Are you pregnant and/or nursing? no ges If yes, how old is your present pair of lenses? Do you wear glasses? no ges If yes, how old is your present pair of lenses? Last eye exam: If no, are you interested in trying them? no ges Doctor's name, phone number: When you wear your glasses or contacts: All the time Reading/Near Work Work Safety Distance task only cher; Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? no ges Family History Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions: DISEASE / CONDITION NO YES? RELATIONSHIP TO YOU Blindness Cataract Blindness Blindness Cataract Blindness Blindness Cataract Blindness Cataract Blindness Blindne	Birth Date / / Age	Social	Security	#	/	1	Work Phone
Medical History Do you have any allergies to medications? no ges If yes, explain: List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): List any major injuries, surgeries and/or hospitalizations you have had: List any of the following that you have had: crossed/turned eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: Are you pregnant and/or nursing? no ges If yes, how old is your present pair of lenses? Do you wear glasses? no ges If yes, how old is your present pair of lenses? Last eye exam: If no, are you interested in trying them? no ges Doctor's name, phone number: When you wear your glasses or contacts: All the time Reading/Near Work Work Safety Distance task only Computer Work Sports Television Hobbies Sun Protection Other: Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? no ges Family History Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions: DISEASE / CONDITION NO YES? RELATIONSHIP TO YOU Blindness Cataract	Name of Medical Doctor	_ 000141	Occurry	"			- Employer
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Are you pregnant and/or nursing?	List any major injuries, surgeries and/o	or hospi	talization	s you ha	ve had:		AND CENTRAL PROPERTY.
Are you pregnant and/or nursing?							13 - Sie 35
Are you pregnant and/or nursing?	List any of the following that you have	had: cr	ossed/tur	ned eye	s, lazy eye,	drooping	eyelid, prominent eyes, glaucoma,
Are you pregnant and/or nursing?	retinal disease, cataracts, eye infectio	ns or ey	e injury:_				
Do you wear glasses?							and the second
Do you wear glasses?	Are you pregnant and/or nursing?	□no	□ yes				1.50 1.61%
Do you wear contact lenses?			-	If ves	s. how old is	s vour pre	sent pair of lenses?
Last eye exam: If no, are you interested in trying them? _ no _ yes Doctor's name, phone number:							
Doctor's name, phone number: When you wear your glasses or contacts: All the time Reading/Near Work Work Safety Distance task only Computer Work Sports Television Hobbies Sun Protection Other: Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? no yes Family History							
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Computer Work Sports Television Hobbies Sun Protection Other: Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? no yes Family History Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions: DISEASE / CONDITION NO YES RELATIONSHIP TO YOU Blindness Galaucoma Galaucom							
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Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions: DISEASE / CONDITION NO YES ? RELATIONSHIP TO YOU Blindness	Family History						
DISEASE / CONDITION NO YES ? RELATIONSHIP TO YOU Blindness			lnavanta	معامانه	المحمدانا والماد	مام مدمال	and all for the fell and the little
Blindness							
Cataract					RELATI	ONSHIP	TO YOU
Crossed Eyes							
Glaucoma Macular Degeneration Retinal Detachment/Disease Arthritis Cancer Diabetes Heart Disease High Blood Pressure Kidney Disease Lupus Thyroid Disease			_	_	-		
Macular Degeneration Retinal Detachment/Disease Arthritis Cancer Diabetes Heart Disease High Blood Pressure Kidney Disease Lupus Thyroid Disease Other							
Retinal Detachment/Disease							
Arthritis					-		
Cancer Diabetes Heart Disease High Blood Pressure Kidney Disease Lupus Thyroid Disease Other							
Diabetes					-		
Heart Disease		7,000	10.00	1950			
High Blood Pressure				10000 E	-		
Kidney Disease					-		
Lupus							
Thyroid Disease	•	100000	1000				
Other			000000	-			
			_		-		

^{*}Please turn this form over and complete side two*

Cancer CONSTITUTIONAL Fever, Weight Loss/Gain Allergies/Hay Fever District Cough Dist		refer to d	iscuss	my Soci	al History information directly with m culty when driving? □ no □yes	y doctor. (check bo	ox)
Do you use illegal drugs?	Do you use tobacco products? □ no	□ yes	If ye	es, type/a	amount/how long:			
Have you ever veen exposed to or infected with: Gonorrhea		•	•					
Review of Systems Do you currently, or have you ever had any problems in the following areas: SYSTEM	Do you use illegal drugs? □ no							
Do you currently, or have you ever had any problems in the following areas: SYSTEM NO YES Cancer Cancer CONSTITUTIONAL Fever, Weight Loss/Gain NEGUMENTARY (Skin) NEUROLOGICAL Headaches Migraines Seizures Chronic Bronchitis EMPINATORY Cholesterol Hart Pain Hart Pain High Blood Pressure High Blood Pressure Vascular Disease Heart Pain GASTROINTESTINAL Burning Foreign Body Sensation Excess Tearing/Watering Excess Tearing/Watering Gastrointestivity Garetials/Kidney/Bladder Excess Tearing/Watering Gastrointestivity Genitals/Kidney/Bladder Excess Tearing/Watering Gastrointestivity Genitals/Kidney/Bladder Genitals/Kidney/Blader Genitals/Kidney/Blader Genitals/Kid	Have you ever veen exposed to or infect	cted with:		Gonorrh	nea □ Hepatitis □ HIV	□ Syphilis		
SYSTEM								
Cancer CONSTITUTIONAL Fever, Weight Loss/Gain INTEGUMENTARY (Skin) NEUROLOGICAL Headaches Migraines Seizures Se	Do you currently, or have you ever had				owing areas:			
CONSTITUTIONAL Fever, Weight Loss/Gain Allergies/Hay Fever				?		NO	YES	?
Fever, Weight Loss/Gain Allergies/Hay Fever District Gough Sinus Congestion District Gough Dry Throat/Mouth Dry Thr						<u>.</u>		
INTEGUMENTARY (Skin) NEUROLOGICAL Headaches Headaches Migraines Seizures RESPIRATORY Seizures Asthma Blurred Vision Blurred Vision Blurred Vision Blurred Vision Blurred Vision Coss of Side Vision Distorted Vision/Halos Loss of Side Vision Double Vision Double Vision Dryness Dry								
NEUROLOGICAL Headaches Migraines Seizures Seizures Loss of Vision Blurred Vision Distorted Vision Distorted Vision Double Vision Double Vision Dryness Mucous Discharge Redness Sandy or Gritty Feeling Burning Burnin								
Headaches Dry Throat/Mouth D		10 To 10			•			
Migraines Seizures Se								
Seizures								
Loss of Vision								
Loss of Vision Emphysema E								
Blurred Vision ENDOCRINE								
Distorted Vision/Halos Thyroid/Other Glands Diabetes Diabetes Diabetes Diabetes Diabetes Diabetes Diabetes Double Vision VASCULAR / CARDIOVASCULAR Cholesterol Dryness Dry					The second secon			
Loss of Side Vision								
Double Vision VASCULAR / CARDIOVASCULAR Dryness Cholesterol Mucous Discharge Heart Pain Redness High Blood Pressure Sandy or Gritty Feeling Vascular Disease Itching GASTROINTESTINAL Burning Diarrhea Burning Obarthea Constipation Excess Tearing/Watering GENITOURINARY Glare/Light Sensitivity Genitals/Kidney/Bladder Eye Pain or Soreness BONES/JOINTS/MUSCLES Chronic Infection of Eye or Lid Rheumatoid Arthritis Sties or Chalazion Muscle Pain Flashes/Floaters in Vision Joint Pain Tired Eyes LYMPHATIC/IMMUNOLOGIC Anemia Anemia Bleeding Problems If you answered YES to any of the above or have a condition not listed, please explain & list medications:					Thyroid/Other Glands			
Dryness					Diabetes	. 🗆		
Mucous Discharge	Double Vision				VASCULAR / CARDIOVASCULA	AR		
Redness	Dryness				Cholesterol			
Sandy or Gritty Feeling	Mucous Discharge				Heart Pain			
Itching	Redness				High Blood Pressure			
Burning	Sandy or Gritty Feeling				Vascular Disease		· 🗆	
Foreign Body Sensation	Itching				GASTROINTESTINAL			
Foreign Body Sensation	Burning				Diarrhea			
Excess Tearing/Watering GENITOURINARY Glare/Light Sensitivity Genitals/Kidney/Bladder Ge	Foreign Body Sensation				Constipation			
Eye Pain or Soreness BONES/JOINTS/MUSCLES Chronic Infection of Eye or Lid Rheumatoid Arthritis Sties or Chalazion Muscle Pain								
Eye Pain or Soreness BONES/JOINTS/MUSCLES Chronic Infection of Eye or Lid Rheumatoid Arthritis Sties or Chalazion Muscle Pain	Glare/Light Sensitivity				Genitals/Kidney/Bladder			
Chronic Infection of Eye or Lid								
Sties or Chalazion								
Flashes/Floaters in Vision				100 m/s		П		
Tired Eyes								
Anemia Bleeding Problems If you answered YES to any of the above or have a condition not listed, please explain & list medications:				_			_	
If you answered YES to any of the above or have a condition not listed, please explain & list medications:	,	_	J					
If you answered YES to any of the above or have a condition not listed, please explain & list medications:								
	If you answered YES to any of the ab	ove or h	ave a	conditio	0			J
					Y			
		•	Date					

Socastee Eye Clinic, Inc.

Patient Acknowledgment Form

Our notice of privacy practices provides information about how we may use and disclose protected
health information about you. You have the right to review our notice before signing this consent. As
provided in our notice, the terms of our notice may change. If we change our notice, you may obtain
a revised copy by contacting the privacy officer, Traci Williams, at 843-293-8101.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance to your prior consent.

Patient's Name (Print)	Patient's Signature
Date	
Email:	