Medical History Questionnaire

Name_____ Today's Date ____/____/____
Address_____ Home Phone _____
City_____ State_____ Zip_____ Cell Phone_____
Birth Date____/____/____ Age_____ Social Security # _____/_____/_____ Work Phone_____
Name of Medical Doctor_____ Phone _____ Employer_____
Last Medical Exam _____

Medical History

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 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 ☐ yes
Do you wear glasses? ☐no ☐yes If yes, how old is your present pair of lenses?_____
Do you wear contact lenses? ☐no ☐yes If yes, how old is your present pair of lenses?_____
Last eye exam:_____ If no, are you interested in trying them? ☐no ☐ yes
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

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	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment/Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other_____	☐	☐	☐	

Please turn this form over and complete side two*

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. (check box)

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes If yes, please describe:

Do you use tobacco products? ☐ no ☐ yes If yes, type/amount/how long:

Do you drink alcohol? ☐ no ☐ yes If yes, type/amount/how long:

Do you use illegal drugs? ☐ no ☐ yes If yes, type/amount/how long:

Have you ever veen exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

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

SYSTEM	NO	YES	?
Cancer	☐	☐	☐
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL	☐	☐	☐
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
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	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
Diabetes	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Cholesterol	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC/IMMUNOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____, O.D. _____

R. Neal Williams, Jr. Date

Dr. Neal Williams

Bringing life into Focus!

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: