Dr. Cade Wilson, O.D.
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P-612-DX

Medical History Questionnaire

Name ____________________ Today's Date: ____________

Birthdate: ___ / ___ / ___ (Month / Day / Year) Age:___ Social Security #:_____ - ____ - _____ Last Eye Exam: _____ / _____ (Month / Year)

Address ____________________ Last Eye Doctor: ____________

City, State, Zip ____________________ Last Medical Exam: ____________

Daytime Phone: ____________ Cell Phone: ____________ Email: ____________

How did you hear about us? ❏ TV ❏ Phone Book ❏ Friend ❏ Referral ❏ Insurance Co.
❏ Other: ____________

Medical History

Current Medical Dr.: ____________

Do you have any allergies to medications? ❏ Yes ❏ No If yes, explain: ____________

List any medications you take (including oral contraceptive, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: ____________

Circle any of the following that you have had: crossed eyes, lazy eye, glaucoma, retinal disease, cataracts, or eye injury.

Are you pregnant and/or nursing? ❏ Yes ❏ No

Do you wear glasses? ❏ Yes ❏ No If yes, how old is your present pair of lenses? ____________

Do you wear contact lenses? ❏ Yes ❏ No If yes, how old is your present pair of lenses? ____________

Type of contact lenses: ❏ Rigid ❏ Soft ❏ Extended Wear ❏ Other Are they comfortable? ❏ Yes ❏ No

Have you had refractive surgery? ❏ Yes ❏ No

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	**Yes**	**No**	**Not Sure**	**Relationship To You**
Blindness	❏	❏	❏	
Cataract	❏	❏	❏	
Crossed Eyes	❏	❏	❏	
Glaucoma	❏	❏	❏	
Macular Degeneration	❏	❏	❏	
Retinal Detachment/Disease	❏	❏	❏	
Systemic Disease/Condition				
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 your prefer.*

❑ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❑ Yes ❑ No If yes, do you have visual difficulty when driving? ❑ Yes ❑ No If yes, please describe:

___

Do you use tobacco products? ❑ Yes ❑ No If yes, type/amount/how long? ___

Do you drink alcohol? ❑ Yes ❑ No If yes, type/amount/how long? ___

Do you use illegal drugs? ❑ Yes ❑ No If yes, type/amount/how long? ___

Have you ever been exposed to or infect with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

Review of Systems

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

System	Yes	No	Not Sure
Constitutional			
Fever, Weight Loss/Gain	❑	❑	❑
Skin (Integumentary)	❑	❑	❑
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	❑	❑	❑
Endocrine			
Thyroid/Other Glands	❑	❑	❑

	Yes	No	Not Sure
Ears, Nose, Mouth, Throat			
Allergies/Hay Fever	❑	❑	❑
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 Plain	❑	❑	❑
Lymphatic/Hematologic			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
Allergic/Immunologic	❑	❑	❑
Psychiatric	❑	❑	❑

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ___ for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

___ *Signature of Beneficiary*

___ *Date*