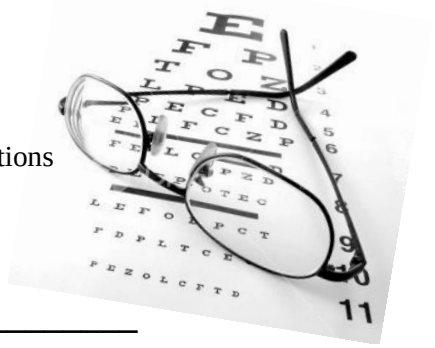
Welcome to Fall River Vision



Thank you for choosing our office for your eye health care. If you have any questions regarding this form, we will be happy to assist you!

Medical History Questionnaire

How did you hear about us? _____

Patient Information: (Please Print)

Today's Date: _____ Date of Birth: _____

Name: _____ Soc Sec #: _____

Address: _____ Primary Insurance: _____

City: _____State:_____ Zip: _____ Member ID #: _____

Phone: H_____ Cell_____ Secondary Insurance: _____

Age: _____ Male/Female Member ID #: _____

Email Address: _____ Last 4 of the insurance subscriber's Soc Sec #: _____

Occupation: _____ Hobbies: _____

Guarantor Information: (Please Print)

Name: _____ Soc Sec #: _____

Address: _____ City: _____State:_____ Zip: _____

Date of Birth: _____ Male/Female Phone: H_____ Cell_____

Patient Medical History:

Date of last eye examination: ___/___/____ Dr's Name: _____ Location: _____ Phone: _____

Date of last physical: ___/___/____ Medical Dr's Name: _____ Location: _____Phone:_____

List any medications you are currently taking: (including contraceptives, aspirin, home remedies and over the counter medications)

_____

_____

_____

Allergies: _____

List of any major injuries, surgeries and or hospitalization and dates they occurred: _____

_____

Circle if you have had any of the following: *Cataract* *Keratoconus* *Retinal Problem* *Macular Degeneration* *Glaucoma* *Surgery* *Injury* *Drooping Eyelid* *Patching* *Amblyopia (lazy eye)* *Strabismus (cross eyes)*

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

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your current pair of lenses? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your current pair of lenses? _____

If yes: Brand/Type of contact lenses: _____ Are they comfortable? ☐ Yes ☐ No

If no: Are you interested in contact lenses? ☐ Yes ☐ No

Are you interested in laser eye surgery? ☐ Yes ☐ No

Family History:

Please note any Family History (Parents, Grandparents, Siblings, Children; living or deceased) for the following conditions:

Disease/Condition	Yes	No	?	Relationship	Disease/Condition	Yes	No	?	Relationship
Blindness	☐	☐	☐	_____	Cancer	☐	☐	☐	_____
Cataract	☐	☐	☐	_____	Diabetes	☐	☐	☐	_____
Cross Eyes	☐	☐	☐	_____	Heart Disease	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____	High Blood Pressure	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____	Kidney Disease	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____	Lupus	☐	☐	☐	_____
Retinal Disease	☐	☐	☐	_____	Thyroid Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____	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? □ Yes □ No if yes, do you have visual difficulty when driving? □ Yes □ No if yes, explain:
_____

Do you use tobacco products? □ Yes □ No if yes, type/amount/how long: _____
Do you consume alcohol? □ Yes □ No if yes, type/amount/how long: _____
Do you use illegal drugs? □ Yes □ No if yes, type/amount/how long: _____

Circle if you have ever been exposed to or infected with: *Gonorrhea* *Hepatitis* *HIV* *Syphilis*

Review of Systems:
Do you currently, or have you had any problems in the following areas:

System	Yes	No	?
Constitutional			
Fever, Weight Loss / Gain	□	□	□
Integumentary (Skin)	□	□	□
Neurological			
Headache	□	□	□
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	□	□	□
Eye Pain or Soreness	□	□	□
Chronic Infection of Eye or Lid	□	□	□
Sties or Chalazion	□	□	□
Flashes / Floaters in Vision	□	□	□
Tired Eyes	□	□	□
Endocrine			
Thyroid / Other Gland	□	□	□
Allergic / Immunologic	□	□	□
Psychiatric	□	□	□

System	Yes	No	?
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	□	□	□
Cholesterol	□	□	□
Diabetes	□	□	□
Heart Pain	□	□	□
High Blood Pressure	□	□	□
Vascular Disease	□	□	□
Gastrointestinal	□	□	□
Diarrhea	□	□	□
Constipation	□	□	□
Genitourinary			
Genitals / Kidney / Bladder	□	□	□
Bone / Joints / Muscles			
Rheumatoid Arthritis	□	□	□
Muscle Pain	□	□	□
Joint Pain	□	□	□
Lymphatic / Hematologic	□	□	□
Anemia	□	□	□
Bleeding Problems	□	□	□

If you answered yes to any of the above, or have a condition not listed, please explain:
_____
_____
_____
_____
_____

For Office Use Only

_____ _____
Doctor's Signature **Date**

11/11/11