SEE NC EYECARE

Medical History Questionnaire

Mr / Mrs / Ms _____ Today's Date _____

☐ Male ☐ Female Social Security # _____ ☐ Minor ☐ Single ☐ Married

Date of Birth _____ Home Phone _____ Cell Phone _____

E-Mail _____

Address _____

City _____ State _____ Zip Code _____

Employer _____ Work Phone _____

Occupation _____ Vision Insurance _____

Primary Insured _____ Primary Insured's SS# _____

Primary Insured's Date of Birth _____ Emergency Contact _____

Do you currently wear glasses? ☐ Yes ☐ No

Are you having any problems with your eyes/vision? _____

Describe how you use your vision at work so we can make the best lens recommendations for you:

_____

What kinds of hobbies, sports, and other interests do you have? (Knowing this enables us to find the best vision correction for you)

_____

Who can we thank for referring you to our office? _____

Your Personal History

☐ Yes ☐ No Do you wear contacts? Type/Brand _____

☐ Yes ☐ No Are you pregnant or nursing? _____

☐ Yes ☐ No Have you had any major injuries, surgeries and/or hospitalizations? If so please list them:

_____

☐ Yes ☐ No Do you take any medications? If so please list them:

_____

Do you currently have or have had the following conditions? Check those that apply:

Allergic/Immunologic

☐ Drug Allergy _____

☐ Environmental Allergy _____

☐ Rheumatoid Arthritis

Cardiovascular

☐ Heart Disease
☐ Hypertension
☐ Stroke

General Health

☐ Head Trauma
☐ Headaches
☐ Cancer

Eyes

☐ Retinal Detachment
☐ Glaucoma
☐ Cataracts
☐ Macular Degeneration
☐ Lazy Eye
☐ Eye Infections
☐ Eye Injury
☐ STD/HIV Herpes

Hematologic/Lymphatic

☐ Anemia
☐ Leukemia

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Ear/Nose/Throat

☐

Dermatologic

☐ Eczema
☐ Rosacea
☐ Psoriasis

Endocrine

☐ Thyroid
☐ Diabetes

Musculoskeletal

☐ Muscular Dystrophy
☐ Osteoarthritis
☐ Ankylosing Spondytitis

Neurological

☐ Multiple Sclerosis
☐ Epilepsy

☐ **Gastrointestina**

Respiratory

☐ Asthma
☐ Emphysema

Family History

Does any family member (parents, grandparents, siblings, children) currently have or have had any of the following conditions? Please write relationship to you.

☐ Glaucoma
☐ Blindness
☐ Cataracts
☐ Crossed Eyes
☐ Macular Degeneration
☐ Retinal Detachment/Disease
☐ High Blood Pressure
☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ Thyroid Disease
☐ Other

Health History Update

Changes in Medical History? ☐ Yes ☐ No

List Changes	Date	Patients Initials

Payment Policy:
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. 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. Eyeglasses are like fingerprints and are custom made for each patient. There will be no refunds for products or services and orders cannot be cancelled for any reason once they have been placed. Orders not picked up within 60 days will be returned and deposits will be lost. I also acknowledge that See NC Eyecare's Notice of Privacy is available for me to read in the waiting room at any time and copies will be given upon request.

To the best of my knowledge, the above information is correct.

Patient's Signature or Parent/Guardian Date