Medical History Questionnaire

Name_____ Date_____
Last Eye Exam_____Last Eye Doctor_____
Last Visit to Medical Doctor_____Medical Doctor_____
Pharmacy? _____Reason for today's visit_____

List **ALL** medications, prescription or non-prescription, including any eye drops:
_____
_____
_____
List any medications you are allergic to: _____
List all surgeries(including eye surgeries and year if known):
_____
_____

Are you pregnant or nursing? Yes No

Eye: Do you currently have or have had any of the following: (Please circle all that apply)

Glaucoma	Blurry Vision	Sandy/Gritty Feeling
Cataracts	Double Vision	Itching
Macular Degeneration	Loss of Side Vision	Burning
Retinal Detachment	Eye Pain or Soreness	Mucous/Discharge
Flashes/Floaters	Redness	Glare/Light Sensitivity
Loss of Vision	Tearing/Watering	Tired Eyes
Chronic Styes		

Do you wear glasses? Yes No If no, have you ever worn them before? Yes No
Do you wear contact lenses? Yes No Type: gas perm/disposable/toric/dailies/mono
Contact lens wear schedule: daily or extended Disposal time: 2 week 1 month 3 month

Social History: (You may discuss this section directly with the doctor or technician if you prefer)
Do you drive? Yes No Do you have visual difficulty driving? Yes No
Do you smoke? Yes No How many years? _____ Packs per day? _____
Do you drink alcohol? Yes No Daily Socially Rarely
Have you ever been exposed to any sexually transmitted diseases? Yes No

Family History: Do **YOU** or anyone in your immediate family (**blood relative**) have any of the following conditions? (List their relation to you)

Glaucoma	Yes	No _____	High Blood Pressure	Yes	No _____
Cataracts	Yes	No _____	Arthritis	Yes	No _____
Macular Deg.	Yes	No _____	Kidney Disease	Yes	No _____
Retinal Det.	Yes	No _____	Thyroid Disease	Yes	No _____
Blindness	Yes	No _____	Diabetes	Yes	No _____
Stroke	Yes	No _____	Cancer	Yes	No _____
Heart Disease	Yes	No _____	Other not listed _____		

(OVER)

Personal Medical History:

Cardiovascular	High Blood Pressure	Yes	No	**Height** _____
	Heart Disease	Yes	No	**Weight**_____
	Stroke	Yes	No	

Endocrine	Diabetes	Yes (Insulin/Noninsulin)	No
	Thyroid	Yes	No

Gastrointestinal (Crohn's Disease, colon cancer, acid reflux, ulcers) Yes No

Genitourinary (Bladder infections, kidney stones, ovarian cysts or tumors, prostate cancer) Yes No

Hematological (Anemia, leukemia, sickle cell disease, bleeding or clotting problems) Yes No

Immunologic (HIV or AIDS, herpes, tuberculosis, syphilis) Yes No

Integumentary (Lupus, Psoriasis, other skin problems) Yes No

Musculoskeletal (Arthritis, rheumatoid arthritis, muscular dystrophy) Yes No

Neurological (Headache, Bell's Palsy, epilepsy, seizures) Yes No

Psychiatric (Depression, bi-polar, insomnia, schizophrenia, anxiety) Yes No

Respiratory (Asthma, emphysema, COPD) Yes No

Privacy Policy

I hereby authorize the release of this confidential health information to the following persons. I understand that this information may be used and disclosed by the receiving entity. A photo copy or fax of this authorization is valid as the original. I reserve the right to revoke this authorization in writing. I acknowledge that I received a copy of the Notice of Privacy Policies.

Sign_____ **Date**_____

List any persons to whom we have permission to release your records: (Family Member, Friend, Doctor, Etc.)

_____

I, the undersigned, certify that I (or dependent) have coverage with the given insurance and assign directly to Dr. Shanna F. Kirk (May) all insurance benefits. I understand that I am financially responsible for all whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment charges of benefits. I authorize the use of this signature on all insurance submissions. Certain routine services and/or materials that we feel are necessary for good health may not be covered by your insurance. You will be expected to pay for those services and/or materials in full. Should your account become delinquent and require services of a collection agency or an attorney, you will pay reasonable collection fees, attorney fees, and all court costs for collection. All materials purchased are final unless a manufactures defect occurs.

Once orders are made, they cannot be returned and full payment is required. You will also be responsible for a $25 refraction if one is incurred at the time of the visit. By signing this consent form, you are agreeing that Dr. Shanna May can electronically transmit your prescriptions directly to your pharmacy.

E-Prescribing is an optional service and you may choose to decline. Please note that consenting to EPrescribing also permits the use of your prescription medication history from other healthcare providers and/or third-party benefit payors (i.e., your insurance company) for treatment purposes only. Understanding all of the above, I hereby provide informed consent to Dr. Shanna F. May to enroll me in the E-Prescribe Program.

Sign_____**Date**_____

Print Name_____ Revised 2/13/2015