Medical History Questionnaire

Name: _____ DOB: ___/___/___ Date: ___/___/___

Medical History:

Do you have any allergies to medications? ☐ No ☐ Yes If yes, explain: _____

_____

List any medications you are taking (include oral contraceptives, aspirin, over the counter medications and home remedies): _____

_____

_____

Circle any of the following surgeries that you have had: Hysterectomy, Gallbladder, Vertebrae, Vasectomy, Appendectomy, Tonsillectomy, T&A (tonsils and adenoids), Cataract Surgery, Lasik, Sleep apnea, Stents
List any others: _____

Circle any of the following that you have had: crossed 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

Do you wear contact lenses? ☐ No ☐ Yes

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes

Family History:

Please note any family history (parents, grandparents, sibling and/or children, living or deceased for the following medical conditions:

DISEASE/CONDITION	NO	YES	?	Relationship to you
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed/Lazy Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macula Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other	☐	☐	☐	_____

Social History

Do you use tobacco products? ☐ No ☐ Yes _____packs per day

Do you drink alcohol? ☐ No ☐ Yes Do you work at a computer/VDT? ☐ No ☐ Yes

Do you use addictive agents? ☐ No ☐ Yes

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis ☐ None

Your Medical History:

Review of Systems: Please indicate if any of the following medical conditions pertain to you. **All fields must be marked.**

Integumentary:	No	Yes	?
Eczema	☐	☐	☐
Rosacea	☐	☐	☐
Psoriasis	☐	☐	☐
Other	☐	☐	☐

Genitourinary:	No	Yes	?
Genitals	☐	☐	☐
Bladder	☐	☐	☐
Kidney	☐	☐	☐
STD	☐	☐	☐

Muskuloskeletal:	No	Yes	?
Fibromyalgia	☐	☐	☐
Muscular Dystrophy	☐	☐	☐
Osteoarthritis	☐	☐	☐
Ankylosing Spondylitis	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Muscle pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lupus	☐	☐	☐

Neurologic:	No	Yes	?
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Epilepsy	☐	☐	☐

Psychiatric:	No	Yes	?
Depression	☐	☐	☐
Panic Disorder	☐	☐	☐
Schizophrenia	☐	☐	☐
Nerves	☐	☐	☐
Other	☐	☐	☐

Eyes:	No	Yes	?
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body	☐	☐	☐
Excess Tearing	☐	☐	☐
Light Sensitivity	☐	☐	☐
Eye pain	☐	☐	☐
Chronic Infection	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters	☐	☐	☐
Tired Eyes	☐	☐	☐

Gastrointestinal:	No	Yes	?
Crohn's	☐	☐	☐
Colitis	☐	☐	☐
Ulcer	☐	☐	☐
Digestive	☐	☐	☐
Acid Reflux	☐	☐	☐
Irritable Bowel	☐	☐	☐
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Other	☐	☐	☐

Respiratory:	No	Yes	?
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Respiratory Infection	☐	☐	☐

Endocrine:	No	Yes	?
Diabetes	☐	☐	☐
Thyroid Dysfunction	☐	☐	☐
Hormonal Dysfunction	☐	☐	☐

Vascular:	No	Yes	?
Heart Disease	☐	☐	☐
Stroke	☐	☐	☐
High Blood Pressure	☐	☐	☐
Cholesterol	☐	☐	☐
Heart Pain	☐	☐	☐
Other	☐	☐	☐

Constitutional:	No	Yes	?
Disability	☐	☐	☐
Weight Loss/Gain	☐	☐	☐
Fever	☐	☐	☐
Fatigue	☐	☐	☐
Trauma	☐	☐	☐

Ears, Nose, Mouth, Throat:	No	Yes	?
Allergies	☐	☐	☐
Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐

Lymphatic/Hematologic:	No	Yes	?
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Leukemia	☐	☐	☐
Blood Thinner	☐	☐	☐
Large Blood Loss	☐	☐	☐
Other	☐	☐	☐

(OFFICE USE ONLY)

P,F, S Hx Prob Pertient (1 area)_____
Complete (2-3 areas) _____
ROS Prob Pertient (1 sys) _____
Ext. (2-9) _____
Complete (>10) _____

☐ Primary ROS taken today

☐ Reviewed ___/___/___ ROS &PFSH today

☐ Reviewed ___/___/___ ROS &PFSH today

☐ Reviewed ___/___/___ ROS &PFSH today

☐ Reviewed ___/___/___ ROS &PFSH today

Changes Noted:

Initials: _____ Date:_____
_____ Date:_____
_____ Date:_____
_____ Date:_____

Signature:

X _____ Date

X _____ Date

X _____ Date

X _____ Date

CASE HISTORY: Prob-focused _____ Exp. Prob-focused _____ Detailed _____ Comprehensive _____

Patient Registration Form Corinth Eye Clinic, Inc.

(ALL QUESTIONS MUST BE ANSWERED COMPLETELY)

LAST Name:_____ **FIRST Name:**_____ **MI**_____

Street Address:_____ **City:**_____ **State:**____ **Zip:**_____

Home Phone:(____)_____ **Alt. Phone:**(____)_____ **DOB:**____/____/____ **Age:**____

SSN: _____/_____/_____ **Email address:** _____

❑Female ❑Male **Race:** ❑Caucasian ❑African-American ❑Hispanic **Marital Status:** ❑Single ❑Married

******Insurance Information—PLEASE GIVE US YOUR MOST CURRENT INSURANCE CARD******

Insured Name: _____ **Insured Address:**_____

Insured DOB:_____ **Insured SS #:**_____

Insured Phone:_____ **Alt. Phone:**_____

Insured Employer/Address:_____

Employer's Name:_____ **Work Phone:**_____

Employer's Address: _____ **City:**_____ **State:**____ **Zip:**_____

Responsible Party's Name: _____ **Relationship:**_____

Responsible Party's Address: _____ **City:**_____ **State:**____ **Zip:**_____

Responsible Party's Employer:_____ **Work Phone:**_____

Emergency Contact:_____ **Relationship:**_____

Contact's Home Phone:_____ **Contact's Work Phone:**_____

Is your condition work related? ❑Yes ❑No **Automoblie Accident?** ❑Yes ❑No

Were you referred to our office by a medical doctor? ❑Yes ❑No **If yes, what is their name?** _____

Address/Phone: _____

Authorization to Release Medical Records and Information

This authorizes you to release to **Corinth Eye Clinic, Inc**., located at **3201 Gaines Road, Corinth, MS 38834**, their agents or representatives, full and complete medical records, evaluations, consultations or information (hereinafter collectively referred to as "medical records") you may have in custody concerning the undersigned patient. The undersigned represents and warrants that he/she has full authority to request said records and to agree to all the conditions recited herein.

The undersigned expressly releases and forever discharges and agrees to identify and hold harmless **Corinth Eye Clinic, Inc.,** its directors, officers, agents, employees, successors and assigns from any and all claims, damages, actions, causes of action or suits of any kind or nature whatsoever arising our of, or from, the release of any medical records pursuant to this authorization.

_____ _____ _____

Signature of Patient/Responsible Party **Signature of Witness** **Date**