

Medical History Questionnaire

Today's Date _____

Name: _____

Birth date ____/____/____

Address: (street) _____

Home phone: _____

(city) _____

Cell phone: _____

(state) _____ (zip) _____

Work phone: _____

Sex : (circle one) Male Female Marital Status: (circle one) S M D W

Social Security Number: _____ Full-time student: Yes / No Grade in school ____

Employer: _____ Occupation: _____

Vision Insurance: _____ Medical Insurance: _____

Subscriber's name: _____ Does your insurance require a referral? Yes / No

Spouse: _____ Legal guardian: _____

Medical History

Last medical exam: _____ Last eye exam: _____

Do you have any allergies to medications or latex? Yes / No List any allergies _____

List any medications you take, including contraceptives, over the counter medications and home remedies: _____

List dates and types of all major injuries, surgeries, and/or hospitalizations you have had: _____

Circle any of the following you have had: eye injury lazy eye drooping eyelid prominent eyes
glaucoma retinal disease cataracts other eye problem: _____

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 Daily Are they comfortable? ____

Do you need safety glasses for work? Yes / No

Have you ever had your eyes dilated? Yes / No If yes, did you have a reaction to the drops? Yes / No

Are you pregnant and /or nursing? Yes / No

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

Social History This information is strictly confidential. You may discuss this portion directly with the doctor if you prefer.

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

Do you drink alcohol? Yes / No If yes, how many drinks per week? _____

Do you use illegal drugs? Yes / No If yes, types/amount/for how long? _____

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

Family History

Please note any family history for the following conditions (parents, grandparents, siblings, children, living or deceased)

Diseases/Conditions	No	Yes	Not sure	Relationship to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal disease/detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Review of systems Do you currently or have you ever had any problems in the following areas?

	No	Yes	Not sure		No	Yes	Not sure
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever, weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies, hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth/throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES				RESPIRATORY			
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred distance vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred near vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision/halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR/CARDIOVASCULAR			
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/kidney/bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES/JOINTS/MUSCLES			
Glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic infection of eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sty or chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC			
Flashes/floaters in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer vision problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

If you have another condition that is not listed, please explain: _____

**Dr. Lily Yeh, O.D.
139 Hazard Avenue, Building 1, Unit 1
Enfield, CT 06082
860-749-1233
Fax: 860-749-4613**

YOUR CONTACT LENS NOTIFICATION:

Today's successful contact lens progress evaluation is an essential element of your continued contact lens' safety and comfort. Always pay very close attention to any out-of-the-ordinary symptoms or eye irritation. Many factors may interfere with optimum contact lens performance. These can include ocular inflammation or infection, changes in prescription, dry eyes, seasonal allergies, improper lens' discard timetable, overwearing of contacts, irritation from smoking, environmental influences, cosmetics, and lens care product compatibility.

Contact lenses require a medical prescription and, at a minimum according to federal law, a yearly progress evaluation to renew their ocular suitability and vision accuracy. All contact lens wearers need to annually update their contact lens prescription which is not the same as an eyeglass prescription because it includes a base curve, diameter, and brand name. This is in addition to a routine eye exam. There is a contact lens re-evaluation fee, the amount for which varies according to the type of contact lens you wear.

I understand that an annual contact lens re-evaluation is required in order to purchase contact lenses. This service is not included in my routine eye exam and may not be covered by my insurance.

Signature: _____

Date: _____

Printed name: _____

ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Emily Eye Care, LLC
Lily Yeh, O.D. and Laura Mafuz, O.D.
139 Hazard Avenue, Building 1, Enfield, CT 06082
Phone: (860)749-1233
Fax: (860)749-4613

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

**Signing this document signifies that you have received
a copy of our *Notice of Privacy Practices*.**

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from the office of Dr. Lily Yeh.

Signature Date

If signing this as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Relationship to Patient Print Name

Source of authority: _____