MEDICAL HISTORY QUESTIONNAIRE

New York Vision Associates Inc.

Name: Mr. Ms. Mrs. Dr. ______________________________________ **Today's Date:** _____/_____/__________

Address:____ **Home Phone:**______________________

City:___________________________ **Zip:**________________ **Work Phone:**______________________

Employer ____ **Cell Phone:**_______________________

Birth Date:____/____/_______ **Social Security:**____-___-_____ **Occupation:**_______________________

Email Address:____ **Last Eye Exam:**_____/____/__________

Medical Doctor:______________________________________ **Last Medical Exam:**________________

Referred By: ____

Medical History

Do you have any allergies to medications? ❒ no ❒ yes If yes, explain:_______________________________

____

List any medications you take (Including oral contraceptives, aspirin, over the counter medications and home remedies):

____

____

List all major injuries, surgeries and/or hospitalizations you have had:________________________________

____

List, or circle any of the following that you have had: crossed eye, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease,cataract, eye infection or eye injury: ____________________________________

Are you pregnant and/or nursing? ❒ no ❒ yes

Do you wear glasses? ❒ no ❒ yes If yes, how old; glasses?_________________

Do you wear contact lenses? ❒ no ❒ yes If yes, how old; contacts?________________

Type of contact lenses: ☐ Rigid ☐ Soft ☐Disposable ☐Other Are they comfortable? ❒ yes ❒ no

Family History

Please note any family history (parents, grandparents, siblings, children;living or deceased)

DISEASE/CONDITION	**NO**	**YES**	**?**	**RELATIONSHIP TO YOU**
Blindness	❒	❒	❒	____________________________________
Cataracts	❒	❒	❒	____________________________________
Glaucoma	❒	❒	❒	____________________________________
Crossed Eyes	❒	❒	❒	____________________________________
Macular Degeneration	❒	❒	❒	____________________________________
Retinal Detachment/Disease	❒	❒	❒	____________________________________
Arthritis	❒	❒	❒	____________________________________
Cancer	❒	❒	❒	____________________________________
Diabetes	❒	❒	❒	____________________________________
Heart Disease	❒	❒	❒	____________________________________
Kidney Disease	❒	❒	❒	____________________________________
Lupus	❒	❒	❒	____________________________________
Thyroid Disease	❒	❒	❒	____________________________________
Other______________________	❒	❒	❒	____________________________________

Medical Carrier: ____________________ Policy #: ____________________ Grp #: ________________

Policy Holder: _________________ Relationship: _______________ Insured DOB:________________