Thompson and Lett Eye Care, PLLC

Medical History Questionnaire

Name: _____ Today's Date: _____ / _____ /_____
Address: _____ Home Phone: _____
City: _____State____ Zip: _____ Cell Phone: _____
e-mail address: _____ Occupation: _____
Date of Birth: ____ /____ /_____ Social Security#: _____ /____ /_____ Last Eye Exam: _____
Name of Primary Care Physician: _____ Last Medical Exam: _____
How did you hear about our office?_____

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 any of the following that you have had: crossed eyes, lazy eyes, drooping eyelid, protruding eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____
_____

Are you pregnant or nursing? □ no □ yes
Do you wear glasses? □ no □ yes If yes, how old are your current glasses?_____
Do you wear contact lenses? □ no □ yes If yes, do you sleep in them? □ no □ yes

Family History

Please note any family history (parents, grandparents, siblings) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	□	□	□	_____
Cataract	□	□	□	_____
Crossed eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular degeneration	□	□	□	_____
Retinal detachment/disease	□	□	□	_____
Arthritis	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart disease	□	□	□	_____
High blood pressure	□	□	□	_____
Kidney disease	□	□	□	_____
Lupus	□	□	□	_____
Thyroid disease	□	□	□	_____
Other _____	□	□	□	_____

Social History This information is strictly confidential. You may discuss this portion directly with the doctor if you prefer.
□ Yes, I would like to discuss my Social History information directly with my doctor.

Do you drive? □ no □ yes If yes, do you have visual difficulty when driving? □ no □ yes If yes, please explain:
_____

Do you use tobacco products? □ no □ yes If yes, type /amount /how long: _____
Do you drink alcohol? □ no □ yes If yes, type /amount /how long: _____

Please Continue on Other Side

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Review of Systems
Do you currently, or have you ever had any problems with the following items?:

SYSTEM	NO	YES	?		NO	YES	?
Constitutional				**Ears, Nose, Mouth, Throat**			
Fever, Weight Loss/Gain	☐	☐	☐	Allergies/ Hay Fever	☐	☐	☐
Integumentary (Skin)	☐	☐	☐	Sinus Congestion	☐	☐	☐
Neurological				Runny Nose	☐	☐	☐
Headaches	☐	☐	☐	Post-Nasal Drip	☐	☐	☐
Migraines	☐	☐	☐	Chronic Cough	☐	☐	☐
Seizures	☐	☐	☐	Dry Throat/ Mouth	☐	☐	☐
Eyes				**Respiratory**			
Loss of vision	☐	☐	☐	Asthma	☐	☐	☐
Blurred vision	☐	☐	☐	Chronic Bronchitis	☐	☐	☐
Distorted vision/ Halos	☐	☐	☐	Emphysema	☐	☐	☐
Loss of side vision	☐	☐	☐	**Vascular / Cardiovascular**			
Double vision	☐	☐	☐	Diabetes	☐	☐	☐
Dryness	☐	☐	☐	Heart Pain	☐	☐	☐
Mucous discharge	☐	☐	☐	High Blood Pressure	☐	☐	☐
Redness	☐	☐	☐	Vascular Disease	☐	☐	☐
Sandy or gritty feeling	☐	☐	☐	**Gastrointestinal**			
Itching	☐	☐	☐	Diarrhea	☐	☐	☐
Burning	☐	☐	☐	Constipation	☐	☐	☐
Tired eyes	☐	☐	☐	**Genitourinary**			
Excess Tearing/ Watering	☐	☐	☐	Genitals/ Kidney/ Bladder	☐	☐	☐
Glare/ Light Sensitivity	☐	☐	☐	**Bones/ Joints/ Muscles**			
Eye pain or soreness	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Chronic Infection of Eyelid	☐	☐	☐	Muscle Pain	☐	☐	☐
Styes	☐	☐	☐	Joint Pain	☐	☐	☐
Flashes or Floaters	☐	☐	☐	**Lymphatic/ Hematologic**	☐	☐	☐
Endocrine				Anemia	☐	☐	☐
Thyroid/ Other glands	☐	☐	☐	Bleeding problems	☐	☐	☐
				Allergic/ Immunologic	☐	☐	☐
				Psychiatric	☐	☐	☐

Doctor's Signature_____O.D. Date_____

HIPAA Privacy Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (print full name), have been presented with the Notice of Privacy Policy (the "Policy") of Thompson and Lett Eye Care, PLLC (the "Provider") and have access to a copy of such policy to keep for my records.

_____ (Please initial here) I acknowledge that I have access to and/or have been offered a copy of the Policy

_____ (Please initial here) I refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign, Provider may still provide treatment to me.

Patient/ Parent or Guardian_____ Date_____