## Social History

This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.

Do you use any of the following? Tobacco ☐ Alcohol ☐ Other Substances ☐

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## Review of Systems

Do you currently, or have you ever had problems in the following areas: **PLEASE MARK ANY THAT APPLY**

**Cardiovascular**
- ☐ Heart Disease
- ☐ Elevated Cholesterol
- ☐ Heart Murmur
- ☐ Hypertension
- ☐ Stroke

**Endocrine**
- ☐ Crohn's Disease
- ☐ Diabetes Mellitus
- ☐ Gout
- ☐ Hypoglycemia
- ☐ Renal Disease
- ☐ Thyroid Disorder

**Gastrointestinal**
- ☐ Acid Reflux
- ☐ Colitis
- ☐ Gall Bladder
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Ulcer

**Genitourinary**
- ☐ Ovarian Tumor
- ☐ Prostate Cancer
- ☐ Uterine Cancer
- ☐ Syphilis

**Hematologic/Lymphatic**
- ☐ Anemia
- ☐ Hodgkin's Disease
- ☐ Sickle Cell

**Immunologic**
- ☐ AIDS
- ☐ Herpes Simplex
- ☐ Herpes Zoster
- ☐ HIV
- ☐ Lyme Disease

**Integumentary**
- ☐ Acne
- ☐ Rosacea
- ☐ Lupus Erythematosus

**Musculoskeletal**
- ☐ Arthritis
- ☐ Down's Syndrome
- ☐ Marfan's Syndrome
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Skeletal Disorder
- ☐ Back Pain
- ☐ Muscle or Joint Pain

**Neurological**
- ☐ Bell's Palsy
- ☐ Cerebral Palsy
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Neuralgia
- ☐ Nystagmus
- ☐ Migraine

**Psychiatric**
- ☐ ADD/ADHD
- ☐ Anxiety Disorder
- ☐ Autism
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Learning Disability

**Respiratory**
- ☐ Asthma
- ☐ COPD
- ☐ Cystic Fibrosis
- ☐ Emphysema

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## Family History

Do you have any family history of the following eye diseases?

- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Cataract
- ☐ Blindness
- ☐ Retinal Detachment
- ☐ Diabetic Eye Disease
- ☐ Eye turn (Strabismus)
- ☐ Other _____
- ☐ None

See Other Side

# Medical History Questionnaire

Name: _____ Sex: M ____ F _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell:_____ Email Address_____

Birth Date: _____/_____/_____ SS#_____/_____/_____ Communication Preference: Email / Postal / Phone

Occupation;_____ Employer: _____

Emergency Contact: _____ Phone # _____

Last Eye Exam: _____ Marital Status: S / M / D / W

Race: American Indian or Alaskan / Asian / African-American / Hispanic / Hawaiian or Pacific Islander / White

Preferred Language: English / Spanish If Minor, Parent or Guardian _____

**How did you hear about us?**

Google / Yellow Pages / Radio Ad / Drove By / Friend (Who? ☺ _____)

## Patient Release

I understand that I am financially responsible for all charges, and that all patient amounts are due at the time services are rendered. I request that payment of authorized INSURANCE benefits be made on my behalf to CHICO VISION CARE. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agency any information to determine the benefits payable for related services.

_____ _____

Patient's Signature Date

## Medical History

Do you have any allergies to prescription medications? Yes ☐ No ☐

If Yes, please list _____

List ALL prescription medications currently taking _____

_____

List ALL major injuries, surgeries and/or hospitalizations and dates of occurrence: _____ _____

_____

Have you had any injuries to your eyes or history of eye disease? Yes ☐ No ☐

If Yes, please explain: _____

Are you pregnant and/or nursing? Yes ☐ No ☐

Do you wear glasses? Yes ☐ No ☐ If yes, how old is your present pair of glasses? _____

Do you wear contact lenses? Yes ☐ No ☐ If yes, how old is your present pair of lenses? _____ _____

What brand of contact lenses are you currently wearing? _____

See Other Side