VISIONcare ASSOCIATES
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New Patient
Medical History Questionnaire

PATIENT INFORMATION

Last Name _____

First Name _____ MI ____

Preferred Name _____

Birth Sex ☐ Male ☐ Female

DOB _____ SSN_____

Address _____

City _____ State ____ Zip _____

Primary Phone _____

☐ I opt OUT of text appointment reminders

Secondary Phone _____

Email _____

Communication Preference

☐ Email ☐ Mail ☐ Phone

RESPONSIBLE PARTY *(if other than self)*

First & Last Name_____

Address _____

City _____ State ____ Zip _____

Phone _____

DOB _____ SSN _____

DEMOGRAPHIC INFORMATION

Employment

☐ Employed Full Time ☐ Student Full Time
☐ Employed Part Time ☐ Student Part Time
☐ Not Employed ☐ Retired

Employer _____

Occupation _____

Race

☐ White ☐ Black or African American
☐ Asian ☐ American or Alaskan Native
☐ Other ☐ Hawaiian Native ☐ Decline

Ethnicity

☐ Hispanic/Latino ☐ Not Hispanic/Latino
☐ Native Hawaiian, Pacific Islander ☐ Decline

Marital Status

☐ Married ☐ Divorced
☐ Single ☐ Legally Separated
☐ Widowed

Preferred Language

☐ English ☐ Spanish
☐ Other _____

INSURANCE INFORMATION

Medical Ins. _____ Vision Ins. _____

Member Information (*if other than self*)

Last Name _____ Address _____
First Name _____ City _____ State ____ Zip _____
Date of Birth_____ Phone _____
Sex ☐ M ☐ F SSN _____ Employer _____

PERSONAL MEDICAL & FAMILY HISTORY

Smoking History ☐ Current Every Day ☐ Former Smoker ☐ Current Some Day ☐ Never Smoker

Alcohol Use ☐ None ☐ Less than 1/day ☐ 1-2/day ☐ 3 or more/day

Preferred Pharmacy _____ Location _____

Medical Doctor's Name _____ Location _____

Medical Allergies? ☐ No ☐ Yes, list _____

Are you currently pregnant or nursing? ☐ No ☐ Yes

MEDICAL HISTORY: DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:

Arthritis	☐ No ☐ Yes	High Blood Pressure	☐ No ☐ Yes
Asthma	☐ No ☐ Yes	High Cholesterol	☐ No ☐ Yes
Autoimmune Disease	☐ No ☐ Yes	HIV/AIDS	☐ No ☐ Yes
Colon Cancer	☐ No ☐ Yes	Leukemia	☐ No ☐ Yes
COPD	☐ No ☐ Yes	Lymphoma	☐ No ☐ Yes
Depression	☐ No ☐ Yes	Stroke	☐ No ☐ Yes
Diabetes, Type _____	☐ No ☐ Yes	Other (please list) _____	
End Stage Renal Disease	☐ No ☐ Yes	Surgery: Colectomy	☐ No ☐ Yes

OCULAR HISTORY: DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:

Cataracts	☐ No ☐ Yes	Glaucoma	☐ No ☐ Yes
Dry Eye	☐ No ☐ Yes	Lazy Eye (Amblyopia)	☐ No ☐ Yes
Diabetic Retinopathy	☐ No ☐ Yes	Macular Degeneration	☐ No ☐ Yes
Eye Turn (Strabismus)	☐ No ☐ Yes	Retinal Tear or Detachment	☐ No ☐ Yes
Floaters	☐ No ☐ Yes	Wears Contact Lenses	☐ No ☐ Yes

OCULAR SURGERIES: HAVE YOU HAD ANY OF THE FOLLOWING? IF YES, LIST DATE:

Cataract Surgery	☐ No ☐ Yes _____	Glaucoma Surgery	☐ No ☐ Yes _____
Corneal Transplant	☐ No ☐ Yes _____	Retinal Laser Procedure	☐ No ☐ Yes _____
Eye Turn Surgery	☐ No ☐ Yes _____	LASIK/PRK/SMILE/RK	☐ No ☐ Yes _____
Eyelid Surgery	☐ No ☐ Yes _____	YAG Laser Procedure	☐ No ☐ Yes _____

FAMILY HISTORY: DO YOUR PARENTS, GRANDPARENTS, OR SIBLINGS HAVE ANY OF THE FOLLOWING:

Macular Degeneration	☐ No ☐ Yes	Glaucoma	☐ No ☐ Yes
Eye Turn (Strabismus)	☐ No ☐ Yes	Lazy Eye (Amblyopia)	☐ No ☐ Yes
Retinal Detachment	☐ No ☐ Yes	Blindness	☐ No ☐ Yes

BRING A LIST OF MEDICATIONS OR WRITE BELOW (with dosage & frequency, i.e. aspirin 81mg once a day):

_____

_____

_____