



Harrisville Eye Care

MEDICAL HISTORY QUESTIONNAIRE

PLEASE PRINT AND COMPLETE ALL INFORMATION

Name: _____ Date: _____ Date of Birth: _____ / _____ / _____

Marital Status: Single Married Widowed Divorced Name of Spouse (or Parents of Child): _____

Age: _____ SS# _____ Home Phone: (_____) _____

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

E-Mail Address: _____ Work Phone: (_____) _____

Emergency Contact: _____ ID Number: _____

Employer: _____ Occupation: _____ DOB of Policy Holder: _____ / _____ / _____

Insurance Company: _____ Last Medical Exam: _____ / _____ / _____

Policy Holder: _____ SS# of Policy Holder: _____

Name of Medical Doctor: _____

MEDICAL HISTORY

What Medications are you taking? _____

Do you have any allergies to any medications? NO YES If YES, list the medications: _____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.): _____

Are you pregnant and/ or nursing? NO YES

Do you wear glasses? NO YES If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? NO YES If yes, how old is your present pair of lenses? _____

Type of contact lenses? _____ Are they comfortable? NO YES

DO YOU HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? IF YES, PLEASE EXPLAIN.

	YES	NO	EXPLANATION OF PROBLEM
EYES (Glaucoma, Cataract, etc.)			
Loss of Vision			
Blurred Vision			
Floaters			
Fluctuating Vision			
Distorted Vision (halos)			
Loss of Side Vision			
Double Vision			
Dryness			
Mucous Discharge			
Redness			
Sandy or Gritty Feeling			
Itching/ Burning			
Foreign Body Sensation			
Excess Tearing/Watering			