Flory Optometry, P.A.

MEDICAL HISTORY QUESTIONNAIRE

If documentation is not present, we cannot code or report your claim to insurance.

Name: ______________________________ Today's Date: _____/_____/_____

Birth date: _____/_____/_____ Name of Medical Doctor: ______________________________

MEDICAL HISTORY

Do you have any allergies to medications? ❑ No ❑ Yes
If yes, explain: ______________________________

List any medications you take and dosage. Include over-the-counter medications, oral contraceptives, aspirin, and home remedies.
____
____

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

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? ____________

What type of contact lenses do you wear? ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other
Are your contact lenses comfortable? ❑ No ❑ Yes

FAMILY HISTORY

Note any family history (parents, maternal/paternal grandparents, siblings, children; living or deceased) for the following conditions:

Please turn this form over and complete side two

DISEASE/CONDITION	NO	YES	RELATIONSHIP
Blindness (Z82.1 + vision loss)	❑	❑	____________
Due to injury or disease? ____________			
Cataract	❑	❑	____________
Crossed eyes	❑	❑	____________
Glaucoma (Z83.511)	❑	❑	____________
Macular degeneration	❑	❑	____________
Retinal detachment/disease	❑	❑	____________
Other Eye Disorder (Z83.518)	❑	❑	____________
If yes, please specify ____________			
Alcoholism (Z63.72)	❑	❑	____________
Arthritis (Z82.61)	❑	❑	____________
Asthma (Z82.5)	❑	❑	____________
Cancer/Malignant tumor (Z80.9)	❑	❑	____________
If yes, please specify ____________			
Carrier of genetic disease (Z84.81)	❑	❑	____________
Deafness + Hearing loss (Z82.2)	❑	❑	____________
Diabetes (Z83.3)	❑	❑	____________
If yes, which type? ____________			

DISEASE/CONDITION	NO	YES	RELATIONSHIP
Diseases of circulatory system (Z82.49)	❑	❑	____________
Drug Abuse (Z63.72)	❑	❑	____________
Epilepsy (Z82.0)	❑	❑	____________
Heart Disease	❑	❑	____________
High Blood Pressure	❑	❑	____________
HIV (Z83.0)	❑	❑	____________
Kidney Disease (Z84.1)	❑	❑	____________
Mental/Behavioral Disorders (Z81.8)	❑	❑	____________
Osteoporosis (Z82.62)	❑	❑	____________
Stroke (Z82.3)	❑	❑	____________
Sudden Cardiac Death (Z82.41)	❑	❑	____________
Tobacco Dependence (Z81.2)	❑	❑	____________
Thyroid Disease (Z83.49)	❑	❑	____________
Other (Z84.89*)	❑	❑	____________
If yes, please specify ____________			

SOCIAL HISTORY

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

Do you drive? ❑ No ❑ Yes If yes, do you have visual difficulty when driving? ❑ No ❑ Yes
If yes, please describe: ______________________________

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: ______________________________

Do you use illegal drugs? ❑ No ❑ Yes If yes, type / amount / how long: ______________________________

Have you ever been exposed to or infected with ❑ gonorrhea ❑ hepatitis ❑ HIV ❑ syphilis ❑None

REVIEW OF SYSTEMS

Do you currently have or have you ever had health issues in the following systems? If they are problems that no longer exist, check past only.

	NO	YES	Past ONLY
OCULAR			
Eye fatigue	❑	❑	❑
Eye soreness	❑	❑	❑
Eye pain	❑	❑	❑
Foreign body sensation	❑	❑	❑
Dry/sandy feeling	❑	❑	❑
Redness	❑	❑	❑
Burning	❑	❑	❑
Itching	❑	❑	❑
Watery eyes/excess tearing	❑	❑	❑
Light sensitivity	❑	❑	❑
Mucus-like discharge	❑	❑	❑
Infection	❑	❑	❑
CARDIOVASCULAR (Z86.79)			
Cardiovascular disease	❑	❑	❑
High blood pressure	❑	❑	❑
CONSTITUTIONAL			
Excess/loss of appetite	❑	❑	❑
Fever	❑	❑	❑
Weight gain/loss	❑	❑	❑
ENDOCRINE (Z86.39)			
Diabetes	❑	❑	❑
If yes, which type? ______________			
Thyroid disorder	❑	❑	❑
GASTROINTESTINAL (Z87.19)			
Heartburn	❑	❑	❑
Nausea/vomiting	❑	❑	❑
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENITAL ORGAN DISEASES			
Female (Z87.42)	❑	❑	❑
Male (Z87.438)	❑	❑	❑
HEAD (Ears, nose, mouth, throat)			
Seasonal allergies	❑	❑	❑
Hearing loss	❑	❑	❑
Dizziness	❑	❑	❑
HEMATOLOGIC/LYMPHATIC (Z86.2)			
Anemia	❑	❑	❑
Blood clots	❑	❑	❑
INTEGUMENTARY/SKIN(Z87.2)	❑	❑	❑
If yes, describe: ______________			
MUSCULOSKELETAL (Z87.39)			
Arthritis	❑	❑	❑
Joint pain	❑	❑	❑
Muscle pain	❑	❑	❑
NEUROLOGICAL			
Headaches	❑	❑	❑
Headaches, migraine	❑	❑	❑
Seizures	❑	❑	❑
PSYCHIATRIC (Z86.59)	❑	❑	❑
If yes, describe: ______________			
RESPIRATORY (Z87.09)			
Asthma	❑	❑	❑
Bronchitis, chronic	❑	❑	❑
Emphysema	❑	❑	❑
Persistent coughing	❑	❑	❑
Pneumonia (Z87.01)	❑	❑	❑
URINARY			
Bladder infections (Z87.448)	❑	❑	❑
Urinary infections (Z87.440)	❑	❑	❑
Malignant Neoplasm (tumor)	❑	❑	❑
Location: ______________			
Benign Neoplasm (tumor) (Z86.01)	❑	❑	❑
Location: ______________			
OTHER SPECIFIED CONDITIONS (Z87.898)			
Please list: ______________			

If you answered YES to any of the above or have a condition that is not listed, please explain below:

____

____

____

____

______________________________ ______________________

Doctor's Signature Date