Blake J. Hoffman, OD
Main Street Vision Center
2204 M St.
Belleville, KS 66935

Medical History Questionnaire

Name:_____ Preferred Name:_____ Date of Birth:____/____/____
Social Security #:_____-_____-_____ Email: _____
Address:_____ City:_____ State:_____ Zip:_____
Home #:_____-_____-_____ Cell #:_____-_____-_____
Employer:_____ Occupation:_____ Work #: _____-_____-_____
If you are currently in a Care Facility, please list which one :_____
If you are currently a student, which grade are you in:_____ Which school do you attend:_____
Preferred Language: English / Spanish / Other:_____
Race: White / Hispanic / Asian / African American / Other:_____
Ethnicity: Not Hispanic/Latino / Latino/Hispanic / Other:_____
Communication Preference: English / Spanish / Other:_____
Previous Eye Doctor (*if applicable*):_____ Last Eye Exam Date (*with another doctor*): _____
Primary Physician:_____ Last Physical Date:_____
Emergency contact:_____ Relationship to you: _____ Phone#:_____-_____-_____
Referred by:_____

OFFICE PAYMENT POLICY: *Payment is due at time of service*

Name of person responsible for billing:_____ Phone #:_____-_____-_____
Method of Payment: Cash / Check / Credit Card / Debit Card

INSURANCE INFORMATION

*Please list **all** insurance companies that you would like us to submit charges to. Submission does not guarantee charges will be covered. Charges not covered by insurance will be due **at the time of service**.*

Do you have medical insurance? Yes / No
Please circle your Primary carrier: Medicare / BCBS / Medicaid / Other:_____
Secondary carrier: Medicare / BCBS / Medicaid / Other:_____
Do you have vision insurance? Yes / No
If yes, please circle which one: VSP / SVP / Eye Med / Comp Benefits / Other: _____

PATIENT EYEWEAR INFORMATION

EYEGLASSES			*CONTACT LENSES*		
Do you wear eyeglasses?	Yes	No	Do you wear contact lenses?	Yes	No
Are you interested in new frames?	Yes	No	Are your contacts comfortable?	Yes	No
Are you interested in new lenses?	Yes	No	Type of contacts you wear?	Rigid / Soft / Extended-Wear / Other:_____	
Are you interested in sunglasses?	Yes	No			

SOCIAL HISTORY

Do you drive? Yes / No If yes, do you have difficulty driving? Yes / No
If yes, explain: _____
Tobacco use? Never Smoked / Previous Smoker / Everyday Smoker / Smokeless Tobacco User
Do you drink alcohol? Yes / No If yes, how often do you consume alcohol? _____
Do you use illegal drugs? Yes / No If yes, what type/how long:_____
Are you pregnant? Yes / No If yes, how far along are you?_____
Are you nursing? Yes / No
Have you been exposed to or infected with: HIV/AIDS / HEPATITIS / SYPHILIS / GONORRHEA / CHLAMYDIA / OTHER:_____

MEDICAL HISTORY

CURRENT MEDICATIONS	REASON FOR MEDICATIONS	MEDICATION ALLERGIES
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT MEDICAL/OCULAR HISTORY:

*Please note the members of your family **(i.e maternal grandmother)** who have had the following conditions:*

FAMILY MEDICAL HISTORY	**FAMILY OCULAR HISTORY**
Arthritis_____	Blindness _____
Cancer_____	Cataracts_____
Diabetes_____	Diabetic Retinopathy_____
Heart Disease_____	Glaucoma_____
High Blood Pressure_____	Macular Degeneration _____
Kidney Disease_____	Strabismus/Eye Turn _____
Stroke_____	Amblyopia/Lazy Eye_____
Thyroid Disease_____	Retinal Disorders_____
Other_____	Other _____

Have you ever had surgery on your eyes? Yes / No
If yes, please list what kind and date: _____
Have you ever had any systemic surgery (i.e. gallbladder, hernia)? Yes / No
If yes, please list what kind and date: _____

IN THE PAST 2-3 WEEKS, have you had any of the following:

OCCULAR
___Burning sensation
___Distorted/blurred vision
___Double vision
___Dryness
___Eye pain/soreness
___Eye strain
___Flashes
___Floaters
___Foreign body
___Glare/light sensitivity
___Itching
___Loss of vision
___Mucous discharge
___Redness
___Sandy/gritty feeling
___Tearing/watering
___Tired eyes

ALLERGIES
___Anaphylactic Reaction
___Animal Dander
___Dust
___Environmental
___Molds/Mildew

CARDIOVASCULAR
___Angina/Heart pain
___Cardiovascular disease
___Elevated Cholesterol
___Heart Attack
___Heart Murmur
___High Blood Pressure
___Stroke

CONSTITUTIONAL
___Dizziness
___Excessive Thirst
___Excessive Urination
___Fainting
___Fever
___Fatigue
___Nausea

EARS, NOSE, THROAT
___Chronic Cough
___Dry Mouth
___Ear Infections
___Head Cold
___Meniere's Syndrome
___Sinusitis

ENDOCRINE
___Crohn's Disease
___Diabetes: Last A1C # _____
___Gout
___Hypoglycemia
___Thyroid Disease

GASTROINTESTINAL
___Acid Reflex
___Cancer: colon / liver
___Diverticulosis
___Gall Bladder stones
___Hiatal Hernia
___Pancreatitis
___Stomach Ulcer

GENITOURINARY
___Bladder Infections
___Cancer: Prostate / Ovarian
___Ectopic Pregnancy
___Kidney Stones
___Ovarian Cyst
___Prostate Disorder

HEMATOLOGICAL/LYMPHATIC
___Anemia
___Breast Cancer
___Blood Clots
___Bleeding problems
___Leukemia

INTEGUMENTARY/SKIN
___Acne
___Psoriasis
___Skin Cancer

IMMUNOLOGIC
___Herpes: Simplex/Zoster
___Lupus
___Lyme Disease
___Sjogren's Syndrome
___Staph Infection

MUSCULOSKELETAL
___Arthritis
___Osteoporosis
___Rheumatoid Arthritis
___Scoliosis

NEUROLOGICAL
___Bell's Palsy
___Brain tumor
___Cerebral Palsy
___Epilepsy
___Headaches
___Migraines
___Muscular dystrophy
___Multiple Sclerosis
___Parkinson's Disease
___Seizures
___Trigeminal Neuralgia

PSYCHIATRIC
___ADD
___Anxiety
___Autism
___Bipolar Disorder
___Dementia
___Depression
___Schizophrenia

RESPIRATORY
___Asthma
___Bronchitis
___Emphysema
___Lung infections
___Lung Cancer

OTHER:
_____

Patient Signature:_____Date:_____

Parent/Guardian Signature:_____Date: _____