Center for Family Vision, P.C.

Medical History Questionnaire

Please present all insurance cards and photo ID

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

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

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Birth Date: _____/_____/_____ Social Security #: _____/_____/_____ Dr. Phone: _____

Name of Medical Doctor: _____ Last Eye Exam: _____/_____/_____

Employer: _____ Last Medical Exam: _____/_____/_____

Person to contact in case of emergency: _____ Phone: _____

Parent or Guardian: _____ Phone: _____
Name

Address: _____

Medical History

Height: _____ Weight: _____

Do you have any allergies to medications? ❑ no ❑ yes if yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies) or give list to staff please.

_____

_____

_____

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

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

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: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ no ❑ yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/condition	no	yes	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	
Cataract	❑	❑	❑	
Crossed Eyes	❑	❑	❑	
Glaucoma	❑	❑	❑	
Macular Degeneration	❑	❑	❑	
Retinal Detachment/ Disease	❑	❑	❑	
Arthritis	❑	❑	❑	

Disease/condition	no	yes	?	RELATIONSHIP TO YOU
Cancer	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
High Blood Pressure	❑	❑	❑	
Kidney Disease	❑	❑	❑	
Lupus	❑	❑	❑	
Thyroid Disease	❑	❑	❑	
Other	❑	❑	❑	

Social History

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

❑ yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❑ no ❑ yes If yes, do you have visual difficulty when driving? ❑ no ❑ yes If yes, please describe: _____

** Please turn this form over and complete side two**

CONFIDENTIAL

Social History (Cont'd) *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

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

Date of last tetanus shot _____

Review of Systems

Do you currently have any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES			
Loss of Vision	❑	❑	❑
Blurred 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	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE			
Thyroid/Other Glands	❑	❑	❑

SYSTEM	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post-Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
VASCULAR/CARDIOVASCULAR			
Diabetes	❑	❑	❑
Heart Disease	❑	❑	❑
High Blood Pressure	❑	❑	❑
High Cholesterol	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL			
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENITOURINARY			
Genitals/Kidney/Bladder	❑	❑	❑
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC / HEMATOLOGIC			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
ALLERGIC / IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

Have you ever worn contacts? ❑ Yes ❑ No Are you interested in wearing contact lenses? ❑ Yes ❑ No

Do you work at a computer or video display terminal? ❑ Yes ❑ No

Do you wear sun glasses? ❑ Yes ❑ No

What hobbies or sports do you participate in? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

SIGNATURE OF PATIENT (or parent if a minor) DATE

Thank You

Dr. Eudoxia Tsongalis-Arruda Center for Family Vision, PC

EyeScreen Photographic Examination

We at Center for Family Vision are pleased to provide our patients with an advanced digital retinal exam called EyeScreen. EyeScreen is a high resolution screening photograph of your retina which will help us document, review, and compare your retina over time. We will use the EyeScreen exam to document your retinal image for our charts, screen for eye diseases, and improve our ability to view your internal retinal health at a much higher resolution than a slit lamp or ophthalmoscope.

Dr. Tsongalis-Arruda is concerned about retinal problems such as macular degeneration, glaucoma, retinal holes, detachments, and diabetic retinopathy (all of which can lead to partial loss of vision or blindness). Additionally many symptoms of systemic diseases such as diabetes, the effects of high blood pressure, and other diseases can be detected with the EyeScreen examination.

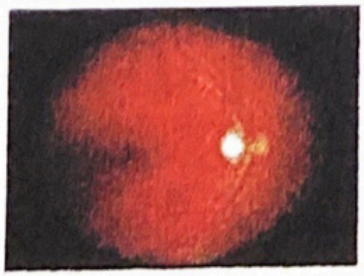
You can expect from this exam:

- *An annual eye wellness EyeScreen photograph*
- *An in depth view of the retinal surface (where eye diseases first manifest)*
- *The ability to review the images with you (we will show you your retina)*
- *A permanent record for your medical file, for serial analysis, comparisons, and diagnosis*
- *To be fast, easy and comfortable*

Since insurances will not pay for the EyeScreen Exam or any retinal image unless eye disease is present—the EyeScreen Examination is an out of pocket expense. Dr. Tsongalis-Arruda recommends this procedure for all of her patients and will perform the EyeScreen Exam at an additional cost of $35.00 to the basic eye exam you are receiving today. Please fill in one of the following circles.

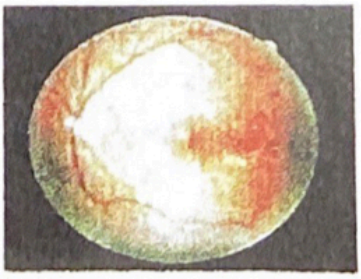
- ○ **I AGREE TO** have my retinal health evaluated with the EyeScreen Exam.
- ○ **I DO NOT AGREE TO** have the Retinal Photographic Exam. I understand that I will still have a thorough eye examination with a slit lamp observation.

Patient Signature_____Date_____



Normal Retina

Suspicious Optic Nerve



Diabetic Disease

Preventative Health Check

1. Have you experience fever, cough, shortness of breath, muscle pain or sore throat? Yes ___ or No ___

2. Have you experienced 2 or more of the following symptoms : chills, repeated shaking with chills, muscle pain, vomiting, red eyes, rash, new loss of taste or smell or headache?

Yes ___ or No ___

3. Have you come into contact with anyone who has tested positive for COVID-19 since your last shift? Yes ___or No ___

4. Have you been tested for COVID-19?

Yes ___ or No ___ date _____ Positive__ or Negative ___

5. Have you returned from international trave or been on a cruise within the last 14 days? Yes ___ or No ___

6. Have you been in contact with anyone who has returned from international travel or been on a cruise within the last 14 days?

Yes ___ or No ___

7. Have you been in any gathering of 10 people or more in the last 14 days? Yes ___ or No ___