WELCOME to our Office ***Medical History Questionnaire***

FAMILY VISION CARE ***Tim M Sellers, O.D***

500 North Parrish Avenue, Adel, Georgia 31620

----------PATIENT INFORMATION----------

Name:_____ **Today's Date:**_____/_____/_____
First Middle Last

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Birth Date:_____/_____/_____ **Social Security #:**_____ **Spouse:**_____

Guardian (*If Applicable***):**_____ **Hm Ph #: ( )**_____ **Wk Ph #: ( )**_____

Occupation:_____ **Employer/School Address:**_____
Address City State Zip

Emergency Contact:_____
Name Relationship Ph # Address City State Zip

----------MEDICAL HISTORY ----------

Have you been diagnosed or treated with any of the following? *(Check all that apply)*

__Glaucoma	**__Blurred Vision**	**__Hypertension**	**__Diabetes**	**__Cancer**	**__Headache**	**__Macular Degeneration**
__Cataract	**__Eye Strain**	**__Heart Disease**	**__Arthritis**	**__Skin Condition**	**__Double Vision**	**__Retinal Detachment**
__Dry Eyes	**__Blindness**	**__Stroke**	**__Lupus**	**__AIDS**	**__Brain Injury**	**__Flashes/Floaters**
__Lazy Eye	**__Eye Redness**	**__Kidney Disease**	**__Thyroid Disease**	**__Addictions**	**__Photosensitivity**	**__Retinal Disease**
__Crossed Eyes	**__Eye Injury**	**__Asthma**	**__Stomach Ulcer**	**__Mental Disease**	**__Eyes burn, itch**	**__Other Explain:**_____

Name of medical doctor:_____ ***Dr's phone #:***_____***Last Medical Exam:***_____/_____/_____

List any medications you are currently taking:_____

_____

List any drug allergies:_____

List any previous surgeries or hospitalizations:_____

****Please inform the doctor if you are pregnant, nursing, or may have become pregnant.***

----------REVIEW OF SYSTEMS----------

Do you currently, or have you ever had any problems in the following systems?

Nervous	**Yes / No**	**Gastrointestional**	**Yes / No**	**Ears, Nose, Mouth, Throat**	**Yes / No**
Respiratory	**Yes / No**	**Cardiovascular**	**Yes / No**	**Bones, Joints, Muscles**	**Yes / No**
Psychiatric	**Yes / No**	**Genitourinary**	**Yes / No**	**Integumentary (Skin)**	**Yes / No**
Neurological	**Yes / No**	**Endocrine**	**Yes / No**	**Hematologic/Lymphatic**	**Yes / No**
Constitutional	**Yes / No**	**Immunologic/Allergic**	**Yes / No**	**Eyes**	**Yes / No**

If you answered YES to any of the above, please explain:_____

_____

----------SOCIAL HISTORY----------

Do you use tobacco products? **Yes / No** ***Do you drink alcohol?*** **Yes / No** ***Do you use other substances?*** **Yes / No**
Do you drive? **Yes / No** ***Any difficulty when driving?*** **Yes / No** ***Explain:***_____
Do you use a computer? **Yes / No** ***How long?***_____ ***Do you read more than thirty minutes per day?*** **Yes / No**
Do you play sports? **Yes / No** ***Describe:***_____
Do you have any hobbies? **Yes / No** ***Describe:***_____
Do you wear glasses, contact lens, safety eyewear, sunglasses, other? **Yes / No**

----------FAMILY HISTORY----------

Have any of your immediate family members been diagnosed or treated with any of the following? *(Check all that apply)*

__Glaucoma	**__Blurred Vision**	**__Hypertension**	**__Diabetes**	**__Macular Degeneration**	**__Other (Please Explain):**_____
__Cataract	**__Lazy Eye**	**__Heart Disease**	**__Cancer**	**__Retinal Detachmet**	_____
__Blindness	**__Crossed eyes**	**__Stroke**	**__Thyroid**	**__Retinal Disease**	_____

We appreciate your business and are proud to serve your eye care needs. Who may we thank for referring you to our office?

_____

Our goal is to offer the best possible service and merchandise. Please feel free to offer any suggestions so that we may serve you better. We want your visit with us to be enjoyable, productive, and informative. We look forward to building a lasting relationship and hope to see you in the years to come.

Sincerely, **Tim M Sellers, O.D.**

*For office use only: Initials*_____