FORD VISION CLINIC

706 F HWY 12 W, STARKVILLE, MS

Eye Health Questionnaire

Social Security No.______________ Date__________ Date of Birth______________

Name______________________________ Phone (H) __________
Last First Middle (O)__________ EXT_____
(Cell)__________

Address______________________________ Zip__________
City State

If P.O. Box please provide physical address______________ email __________

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed SEX ☐ M ☐ F

Business Address______________________________

Occupation______________ Employer______________

Spouse or Responsible Party Information

Name______________ Phone______________

Address______________________________

Social Security Number______________ Date of Birth_______

Where did you hear about us?
(check all that apply)
- ☐ *Friend* __________
- ☐ *Tv/Radio*
- ☐ *Sign*
- ☐ *Website*
- ☐ *Newspaper/Phonebook*

Health Information

Referred by______________ Last Medical Exam______________ Last Eye Exam______________

Name of Physician______________ Phone #______________

Present Medications you are taking: (including over the counter and eye drops)

1)__________ 2)__________ 3.)__________ 4)__________

5)__________ 6)__________ 7)__________ 8)__________

Are you allergic to any medications?______________________________

•Circle any that you have been diagnosed with: Crossed eyes, lazy eyes, drooping lids, glaucoma, retinal disease, or cataracts

•List all major injuries, surgeries and or hospitalizations ______________________________

____

•Do you have any health problems that need further clarification? ______________

If yes, please explain: ______________________________

Please check those that apply:

Medical History
- ☐ *AIDS*
- ☐ *Anemia/Bleeding*
- ☐ *Arthritis*
- ☐ *Asthma*
- ☐ *Bronchitis*
- ☐ *Chronic cough*
- ☐ *Diabetes*
- ☐ *Diarrhea/Constipation*
- ☐ *Dizziness, Fainting*
- ☐ *Dry throat/mouth*
- ☐ *Emphysema*
- ☐ *Epilepsy or convulsions*
- ☐ *General Anesthesia*
- ☐ *Head Injuries*
- ☐ *Headaches/Migranes*
- ☐ *Heart Disease*
- ☐ *Hepatitis/Tuberculosis*
- ☐ *Kidney/Bladder*
- ☐ *Liver Disease*
- ☐ *Low/High blood pressure*
- ☐ *Lung disease*
- ☐ *Nervous Disorders*
- ☐ *Pregnancy-Due Date:*
- ☐ *Respiratory Problems*
- ☐ *Shortness of Breath*
- ☐ *Sinus Problems*
- ☐ *Stomach Problems*
- ☐ *Stroke*
- ☐ *Thyroid/gland problems*

Pathology
- ☐ Allergies __________
  ____
- ☐ *Excessive watering/tearing*
- ☐ *Styes/Chalazions*
- ☐ *Itching/Burning eyes*
- ☐ *Flashes/Floaters*
- ☐ *Color/Depth perception*
- ☐ *Loss of vision*
- ☐ *Double/Distorted vision*
- ☐ *Glare/Halos*
- ☐ *Dry/Sandy/Gritty eyes*
- ☐ *Eye pain/soreness*
- ☐ *Chronic eye infection*
- ☐ *Red eye/Mucus Discharge*

General
- ☐ *Difficulty cooking, dialing telephone or telling time on your watch*
- ☐ *Difficulty reading small print*
- ☐ *Difficulty seeing faces, numbers, or print on TV*
- ☐ *Difficulty with leisure activities*
- ☐ ***Do you enjoy water sports*** ***yes/no***
- ☐ **Do you smoke** **yes/no** How many yrs_____
- ☐ ***Do you use a computer*** ***yes/no***
- ☐ ***Do you wear contacts*** ***yes/no*** How many yrs_____
- ☐ ***Do you wear glasses*** ***yes/no*** How many yrs._____
- ☐ ***Trouble driving at night*** ***yes/no***

In case of an emergency call: ______________________________ Telephone______________

Signature (Parent's signature if minor)______________________________

(SEE NEXT PAGE)

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings (living or deceased) for the following medical conditions.

Blindness YES____________________NO

Cataracts YES ____________________NO

Crossed Eyes YES ____________________NO

Glaucoma YES ____________________NO

Macular Degeneration YES ____________________NO

Retinal Detachment or Disease YES______________NO

Arthritis YES ____________________NO

Cancer YES ____________________NO

Diabetes YES ____________________NO

Heart Disease YES________________NO

High Blood Pressure YES____________NO

Kidney Disease YES________________NO

Lupus YES ____________________NO

Thyroid Disease YES________________NO

Release of Medical Records and Information

This authorizes you to release to FORD VISION CLINIC or their agents or representatives, full and complete medical records, reports, evaluations, consultations or information (hereinafter collectively referred as "medical records") you may have in custody concerning the undersigned patient. The undersigned represents and warrants that he/she has full authority to request said records and to agree to all conditions recited here in. The undersigned expressly releases and forever discharges and agrees to indemnify and hold harmless FORD VISION CLINIC, its directors, officers, agents, employees, and successors and assigns from any and all claims, damages, actions, or suits of any kind or nature whatsoever arising out of or from the release of any medical records pursuant to this authorization.

______________________________________ Date: ____________________ Relationship to Patient____________________

Signature of patient, parent or guardian