

WELCOME TO BURROWS VISION CLINIC, LLC

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Sex: M F Today's date: _____ Spouse's Name: _____

Address: _____ City _____ State _____ Zip _____ Phone _____

Occupation: _____ Employer: _____ Work Phone _____

Birthdate: _____ SSN _____ Date of Last Exam _____

Person responsible for payment: _____ SSN _____

Address: _____ Phone: _____

Name of your medical doctor: _____ Last Medical Exam: _____

Name of VISION Insurance: _____ Medicare & Supplemental? YES NO

Do you have Nebraska Medicaid? YES NO If yes please present card.

Down payment is required to order materials.

For patients without vision insurance we extend a credit of 18% off frame cost when paying the total fee at time of order.

MEDICAL HISTORY - (Circle response)

Do you have any allergies to medications? YES NO if yes, explain: _____

Do you have hay fever allergies _____

List any medications you take: (including over the counter medications, oral contraceptives, aspirin, and home remedies, etc.) _____

List major injuries and surgeries you have had: _____

Circle any of the following you have had: crossed eyes lazy eye eye injury glaucoma retinal disease cataracts

What is the reason for this appointment? _____

Are you pregnant or nursing? YES NO

Do you wear Glasses? YES NO if yes, how old is your present pair of glasses? _____

Do you wear Contact Lenses? YES NO if yes, how old is your present set of lenses? _____

Type of Contact Lenses? RIGID SOFT EXTENDED WEAR OTHER Are they comfortable? YES NO

Are you interested in wearing contact lenses? YES NO

FAMILY HISTORY

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

<u>Disease/Condition</u>	<u>NO</u>	<u>YES</u>	<u>?</u>	<u>Relationship to you</u>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus/Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you:

Have blurry distance vision? Blurry near vision?

Work at a computer for long periods — Any problems? _____

Spend a lot of time outdoors? Have prescription sunglasses?

Have problems with glare or reflection? Especially at night?

Have burning or itching eyes?

Have headaches?

Have sudden loss of vision?

Have trouble reading or learning at work or school?

Who recommended BURROWS VISION to you? _____

(Please turn over and complete side two)

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:

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: _____

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL					EARS, NOSE, MOUTH, THROAT		
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL					Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
EYES					RESPIRATORY		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		VASCULAR / CARDIOVASCULAR		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		GASTROINTESTINAL		
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		GENITOURINARY		
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		BONES / JOINTS / MUSCLES		
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		LYMPHATIC / HEMATOLOGIC		
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE					Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>
					PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>

Thank you, and if you answered YES to any of the above or have a condition **not listed**, please explain & list medications:

Doctor's Signature

Date