DRS. BERGER, TAYLOR & KUNGLE — MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Today's Date: _____
Birth Date: _____ SSN: _____ Last Eye Exam: _____
Address: _____ Last Eye Doctor: _____
City: _____ St: _____ Zip: _____ Last Medical Exam: _____
Phone Number: (h) _____ (w) _____ Current Medical Dr.: _____
E-mail: _____

Vision Insurance Plan: _____ Name of Insured: _____
Member ID Number: _____ Employer: _____
Spouse: _____ Referred by: _____

Reason for visit: _____

Medical History

Do you have any allergies to medications? ❑ Yes ❑ No If yes, explain: _____

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

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

Are you pregnant and/or nursing? ❑ Yes ❑ No If yes, explain: _____
Have you had any eye surgeries? ❑ Yes ❑ No If yes, explain: _____
Have you ever had vision therapy? ❑ Yes ❑ No If yes, explain: _____
Have you ever injured your eyes? ❑ Yes ❑ No If yes, explain: _____
Do you wear glasses? ❑ Yes ❑ No If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? ❑ Yes ❑ No If yes, how old is your present pair or lenses? _____
Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other _____
Name of lenses: _____ Are they comfortable? _____

Review of Systems

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

Visual System	current	past	never
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Double Vision	❑	❑	❑
Halos	❑	❑	❑
Dryness	❑	❑	❑
Redness	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Excess Tearing	❑	❑	❑
Light Sensitive	❑	❑	❑
Eye Pain	❑	❑	❑
Eye Infections	❑	❑	❑
Floaters	❑	❑	❑
Flashes	❑	❑	❑
Tired Eyes	❑	❑	❑
Crossed Eyes	❑	❑	❑
Cataracts	❑	❑	❑
Glaucoma	❑	❑	❑
Retinal Disease	❑	❑	❑

Systemic System	current	past	never
Diabetes	❑	❑	❑
Heart Disease	❑	❑	❑
High Blood Pressure	❑	❑	❑
Urogenital (kidney, bladder)	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑
Blood (Anemia, cholesterol)	❑	❑	❑
Fever	❑	❑	❑
Weight Loss/Gain	❑	❑	❑
Allergies/Hay Fever	❑	❑	❑
Gastrointestinal	❑	❑	❑
Endocrine (thyroid, etc.)	❑	❑	❑
Neurological (MS, seizures)	❑	❑	❑
Skin (acne, cancer)	❑	❑	❑
Psychiatric (depression, etc.)	❑	❑	❑
Headaches/Migraines	❑	❑	❑
Respiratory (asthma, bronchitis, emphysema)	❑	❑	❑
Other: _____	❑	❑	❑

Please fill out the back side...

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.

Do you drive? ❑ Yes ❑ No If yes, do you have visual difficulty when driving? ❑ Yes ❑ No
If yes, please describe: _____
Do you use tobacco products? ❑ Yes ❑ No If yes, type/amount/how long: _____
Do you drink alcohol? ❑ Yes ❑ No If yes, type/amount/how long: _____
Do you use illegal drugs? ❑ Yes ❑ No If yes, type/amount/how long: _____
Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis ❑ None

What type of work do you do? _____
Do you go to school? ❑ Yes ❑ No If yes, where and grade level/field of study? _____
Do you play any sports? ❑ Yes ❑ No If yes, type and amount: _____
Other forms of exercise? _____
Do you have any hobbies? _____
How many hours per day do you:
Work on a computer? _____
Read? _____
Watch TV? _____
Play video games? _____

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	**Yes**	**No**	**Not Sure**	**Relationship to you**
Blindness	❑	❑	❑	
Cataract	❑	❑	❑	
Crossed Eyes	❑	❑	❑	
Glaucoma	❑	❑	❑	
Macular Degeneration	❑	❑	❑	
Retinal Detachment/Disease	❑	❑	❑	
Systemic Disease/Condition				
Arthritis	❑	❑	❑	
Cancer	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
High Blood Pressure	❑	❑	❑	
Kidney Disease	❑	❑	❑	
Lupus	❑	❑	❑	
Thyroid Disease	❑	❑	❑	
Other _____				

Our goal is to provide the best, most complete, up-to-date care available. Our philosophy is preventive and developmental in approach. To provide this service in the most efficient manner, please be aware of the following office policies:

- ❑ *Fees for services are due at the time those services are rendered.*
- ❑ *A deposit is required on all materials and balance due upon delivery.*
- ❑ *We reserve the right to charge for missed appointments not cancelled in advance.*
- ❑ *Visual training patients must notify us of absences in advance.*
- ❑ *There is a charge for written reports.*
- ❑ *Responsibility for payment is the patient's. Insurance agreements are between company and patient. We will assist with proper forms but require reimbursement from patients.*

Signature: _____ *Date:* _____