Medical History Questionnaire

Patient Name____ Today's Date_____________________

DOB_____________________________ Email Address____

Allergies:____

Current Medications:____

____

History of Illness/Medical Conditions____

Diabetes __yes __no

If Diabetic, Taking Insulin__ yes __no and/or Taking Oral Meds for Diabetes __yes __no

High Blood Pressure __yes __no

Patient History of Eye Disease or Problems____

Family History of Eye Disease____

Tobacco Use: ____ Never Smoked ____Former Smoker ____Current Smoker

Have you been infected with any sexually transmitted disease? ___yes ___no

If Yes: ___Gonorrhea ___Syphilis ___Hepatitis ___HIV ___Other

FULL EXAMS ONLY- Retinal photography:

All patients will receive retinal photos which may replace the need for dilation. There is a $39 charge for the photos and will be charged at checkout. NOT applicable for Medicare patients.

Would you like retinal photos?__ YES____ NO____

Vision Ins_____________________ **Medical Ins**____________________ **Secondary Ins**____________________

Policy Holder____________________ Policy Holder____________________ Policy Holder____________________

Policy Holder DOB_______________ Policy Holder DOB_______________ Policy Holder DOB_______________

Insurance ID_____________________ Insurance ID_____________________ Insurance ID_____________________

Group #_________________________ Group #_________________________ Group #_________________________

By my signature I attest that the information I have provided is true and accurate. I will allow Walker Eye Care to verify my medications, including any information that my pharmacy or medical doctor has on file for me.

Signature ____