Gregory J. Goetzinger, O.D. Vision Source

Carthage Vision Clinic 417-359-0600

2020 S. Garrison Ave., Ste. A

PATIENT INFORMATION

Welcome to our office. To better serve your vision and health care needs we need you to please complete this questionnaire and return it to the receptionist when finished. If you have any questions please ask and we will be happy to assist.

Today's Date:_______________

Patient Name: ____ **Home phone #**:______________

First MI Last **Cell phone #**:________________

Date of Birth: ________________ **Age**: ________ **Social Security No.**____________________

Home Address:

____

Street/PO Box City State Zip code

Check Appropiate Box: __Minor__Single__Married **Gender:** ___Male___Female

Email Address: ____ Do we have your permission to email you information regarding confirmations, glasses and/ or contact lens orders, and recalls? **Y/N**

Patient's or parent's employer:

____

Work Phone No.:________________________ **Spouse or Parent's name:**

____

Spouse's employer: ______________________ **Work Phone No.:**

____

Referred by:

____

Medical insurance company:

____

ID #_____________________________________ Policy holder:

____

Vision insurance company:____

ID#____________________________________ Policy holder: ________________________________

MEDICAL HISTORY QUESTIONNAIRE

Please Print

Name:____ **Date:**___________________

Medical Doctor:_______________________________________ **Last medical exam**:__________

Last EyeExam:_____________

List ALL ALLERGIES to medication and foods: ____

List ALL current medications (including oral contraceptives, aspirin, over the counter medications and home remedies:____

____

____

__________________________Pharmacy:________________________________ List all major injuries, surgeries and/or hospitalizations you have had:____

____

____

FAMILY HISTORY

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Cataract			
Crossed Eyes			
Macular Degeneration			
Retinal detachment/Disease			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Thyroid Disease			
Other			

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer

New US Healthcare law requires us to ask the following:

Do you drink alcohol? If yes, how often?		YES	NO
Do you smoke? If yes, how long?		YES	NO
Height			
Weight			

REVIEW OF SYSTEMS

Are you currently having or have a history of the following conditions?

If YES, Please circle symptoms that apply and provide information below.

Patient's current or past eye history:

Redness, gritty feeling, itching, dryness, burning, tired eyes	YES	NO
Loss of vision	YES	NO
Blurry vision	YES	NO
Distorted vision and or halos	YES	NO
Loss of side vision	YES	NO
Double vision If yes, how long and which eye affected?	YES	NO
Glare/light sensitivity	YES	NO
Eye pain and or soreness	YES	NO
Foreign body sensation	YES	NO
Flashes, floaters, tearing or discharge	YES	NO
Chronic infections of the eye or lids	YES	NO
Styes or Chalazion	YES	NO
Glaucoma	YES	NO
Cataract	YES	NO
Macular Degeneration or retinal disease	YES	NO
Have you ever had eye surgery?	YES	NO
Have you ever had an eye injury?	YES	NO
Do you wear glasses or contact lenses? If yes, for how long?	YES	NO
Have you ever had crossed eyes, lazy eye, drooping eyelid or prominent eyes?	YES	NO
Do you plan on changing your eye wear today?	YES	NO

Are you currently having or have had a history of the following medical conditions?

Patient's current or past medical history:

CONSTITUTIONAL SYSTEM: fever, weight loss or other	YES	NO
EARS, NOSE, THROAT-sinus congestion or chronic sinus infections, runny nose, dry mouth/throat or chronic cough	YES	NO
VASCULAR/CARDIOVASCULAR-irregular heartbeat, chest pain, high blood pressure, diabetes, vascular disease	YES	NO
RESPIRTORY- asthma, chronic bronchitis, wheezing, emphysema	YES	NO
GASTROINTESTINAL- genitals, kidney or bladder infections or disease	YES	NO
INTEGUMENTARY-skin rash, scaling, acne	YES	NO
NEUROLOGICAL- weakness, numbness, tingling, headaches, migraines or seizures	YES	NO
ENDOCRINE- diabetes, thyroid disease, heat or cold intolerance, hair loss or growth, changes in menstrual cycle	YES	NO

HEMATIOLOGIC/LYMPHATIC- anemia, bleeding problems, hepatitis	YES	NO
ALLERGIC/IMMUNOLOGIC- seasonal allergies, hay fever symptoms	YES	NO
ARE YOU PREGNANT? If Yes, how many weeks?	YES	NO