20/20 Vision Care

Dr. Jaime Hall-Malouf

MEDICAL HISTORY

PATIENT INFORMATION

Date ____/____/_____

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Email _____

Emergency Contact _____ Phone _____ Relationship _____

Social Security # _____ DOB _____ Age _____ Sex : Male/Female

Driver's License # _____ Marital Status: Single ____ Married ____ Divorced ____ Widowed ____

RESPONSIBLE PARTY *Must be completed if patient is a minor.* PCP Phar

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Email _____

Social Security # _____ DOB _____ Relationship _____

INSURANCE INFORMATION *Is Patient Primary on Policy Y/N, If yes, do not fill out this section.*

Do you have medical insurance? Yes/No Do you have vision insurance? Yes/No

Primary Insurance Company _____ Policy # _____

Policy Holder _____ Relationship _____

Social Security # _____ DOB _____ Sex : Male/Female

Secondary Insurance Company _____ Policy # _____

EMPLOYMENT INFORMATION FOR PATIENT or RESPONSIBLE PARTY

Employer _____ Occupation _____

Student: Full time/Part time

How did you hear about us? Friend/Family _____ Yellow Pages _____ Signs _____

Insurance _____ Doctor _____ Other _____

When was your last eye exam? _____ Do you wear: Contacts Y/N Glasses Y/N

Are you interested in contacts? Y/N

REVIEW OF SYSTEMS *Do you currently, or have you ever had, any problems in the following areas, please check the applicable:*

	Yes	No
Constitutional:		
Fever, weight loss/gain	___	___
Integumentary: Skin	___	___
Neurological:		
Headaches	___	___
Migraines	___	___
Seizures	___	___

	Yes	No
Ear, Nose, Mouth, Throat:		
Allergies/Hay Fever	___	___
Sinus Congestion	___	___
Runny Nose	___	___
Post-nasal drip	___	___
Chronic Cough	___	___
Dry Throat/Mouth	___	___

	Yes	No
Eyes: Loss of Vision	___	___
Blurred Vision	___	___
Distorted Vision/Halos	___	___
Loss of Side Vision		
Double Vision	___	___
Dryness	___	___
Mucous Discharge	___	___
Redness	___	___
Sandy or Gritty Feeling	___	___
Itching	___	___
Burning	___	___
Foreign Body Sensation	___	___
Excess Tearing/Watering	___	___
Glare/Light Sensitivity	___	___
Eye Pain or Soreness	___	___
Chronic Infection	___	___
Sties or Chalazion	___	___
Flashes/Floaters	___	___
Endocrine: Thyroid/other glands	___	___
Allergic, Immunologic	___	___
Psychiatric:	___	___

	Yes	No
Respiratory:		
Asthma	___	___
Chronic Bronchitis	___	___
Emphysema	___	___
Vascular/Cardiovascular:		
Diabetes	___	___
Heart Pain	___	___
High Blood Pressure	___	___
Vascular Disease	___	___
Gastrointestinal:		
Chronic Diarrhea	___	___
Chronic Constipation	___	___
Genitourinary:		
Genitals/Kidney/Bladder	___	___
Bones, Joints, Muscles	___	___
Rheumatoid Arthritis	___	___
Muscle Pain	___	___
Joint Pain	___	___
Lymphatic, Hematologic:		
Anemia	___	___
Bleeding Problems	___	___

Please list any other conditions not listed that you have been diagnosed with or being treated for:

_____

_____

Do you have any allergies: If yes, specify:

_____

_____

Do you or anyone in your family have any of the above conditions?

_____

_____

List all medications that you are taking, include over the counter and home remedies:

_____

_____

_____

_____

Are you pregnant or nursing: Y/N

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

Do you use tobacco products? Y/N If yes, type/amount/how long _____

Do you drink alcohol? Y/N If yes, type/amount/how long _____

Do you use illegal drugs? Y/N If yes, type/amount/how long _____

Have you ever been exposed to or infected with: Gonorrhea ____ Hepatitis ____ HIV ____ Syphilis ____ TB ____

We perform a yearly dilated exam on all patients, especially if you have any of the above conditions. Dilation last about 3 hours and the side effects are blurred vision at near and sensitivity to sunlight.

_____ **I refuse dilation of my eyes today.**