20/20 Vision Care
Quality Eye Care You Can Count On!

Dr. Jaime Hall-Malouf

MEDICAL HISTORY

PATIENT INFORMATION Date___/___/____

Last Name_____First Name_____MI_____

Address_____City_____State_____Zip_____

Phone – Home_____Work_____Cell_____

Social Security #_____DOB_____Age:_____ Sex: Male/Female

Drivers 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_____

DOB:_____Social Security #_____ Relationship_____

Phone – Home_____Work_____Cell_____

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_____

DOB_____ Sex: Male/Female Social Security #_____

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_____

Emergency Contact_____Phone_____Relationship_____

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		Yes	No
Constitutional:			Ear, Nose, Mouth, Throat:		
Fever, weight loss/gain	___	___	Allergies/Hay Fever	___	___
Integumentary: Skin	___	___	Sinus Congestion	___	___
Neurological:			Runny Nose	___	___
Headaches	___	___	Post-nasal drip	___	___
Migraines	___	___	Chronic Cough	___	___
Seizures	___	___	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.***